## Filing at a Glance

| | |
|---|---|
| Company: | The Guardian Life Insurance Company of America |
| Product Name: | Group Dental PPO |
| State: | Tennessee |
| TOI: | H10G Group Health - Dental |
| Sub-TOI: | H10G.000 Health - Dental |
| Filing Type: | Form/Rate |
| Date Submitted: | 05/31/2013 |
| SERFF Tr Num: | GARD-129055732 |
| SERFF Status: | Assigned |
| State Tr Num: | H-130795 |
| State Status: | Assigned - Pending Review |
| Co Tr Num: | 0146GUA01-03 |
| Implementation Date Requested: | On Approval |
| Author(s): | Victoria Arama, Marilyn Young, Joe Collins, Melanie Glassic, Heather Gulla, Jeff Kulesus |
| Reviewer(s): | Vicky Stotzer (primary), Melissa Merritt |
| Disposition Date: | |
| Disposition Status: | |
| Implementation Date: | |

State Filing Description:
G EHP DEN P
GP-1-FFM-13-TN
group EHB dental product

**State:** Tennessee **Filing Company:** The Guardian Life Insurance Company of America
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health - Dental
**Product Name:** Group Dental PPO
**Project Name/Number:** Group Dental Products Project/0146GUA01-03

## General Information

Project Name: Group Dental Products Project
Project Number: 0146GUA01-03
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 06/03/2013
State Status Changed: 06/03/2013
Created By: Heather Gulla
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Heather Gulla

Filing Description:

The attached FFM Filing related forms are being submitted to your Department for review and approval for use in the State of Tennessee for purposes of selling group dental plans through the Health Insurance Marketplace beginning in 2014. These forms are new and do not replace any other previously submitted form.

Please note that upon approval, we intend to use such forms on the Exchange, as well as the open market.

Group Policy Form GP-1-FFM-13-TN reflects a policy shell, setting forth the terms and conditions between the policyholder and Guardian.

Certificate Form GC-EHB-FFM-13-TN describes the dental insurance provisions applicable to an insured person and will be incorporated into the Group Policy as an integral part and will, upon approval, be issued with schedule of benefit Forms SCH1-EHB-PPOHIGH-FFM-TN and SCH2-EHB-PPOLOW-FFM-TN.

Certificate Form GC-SUPP-FFM-13-TN describes the dental insurance provisions applicable to an insured person and their family and will be incorporated into the Group Policy as an integral part and may, upon approval, be issued with schedule of benefit Forms SCH1-SUPP-PPOHIGHORTH-FFM-TN, SCH3-SUPP-PPOLOWORTH-FFM-TN, SCH2-SUPP-PPOHIGH-FFM-TN and SCH4-SUPP-PPOLOW-FFM-TN.

Variable material in the submitted forms are outlined and numbered to correspond with the Variable Memoranda explanations provided with this submission.

Upon approval, we plan to issue the approved forms printed and assembled in a traditional paper process and electronically through the Company’s policy issue system.

Your early consideration of this submission is greatly appreciated.

## Company and Contact

### Filing Contact Information

Heather Bleamer, Contract Analyst
7 Hanover Square
H 22-C
New York, NY 10011

Heather_bleamer@glic.com
610-807-7676 [Phone]

***State:*** *Tennessee* ***Filing Company:*** *The Guardian Life Insurance Company of America*
***TOI/Sub-TOI:*** *H10G Group Health - Dental/H10G.000 Health - Dental*
***Product Name:*** *Group Dental PPO*
***Project Name/Number:*** *Group Dental Products Project/0146GUA01-03*

### Filing Company Information

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004
(212) 598-8704 ext. [Phone]

CoCode: 64246
Group Code: 429
Group Name:
FEIN Number: 13-5123390

State of Domicile: New York
Company Type: Life
State ID Number:

## Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *GARD-129055732* | ***State Tracking #:*** | *H-130795* | ***Company Tracking #:*** | *0146GUA01-03* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *The Guardian Life Insurance Company of America* |
| ***TOI/Sub-TOI:*** | *H10G Group Health - Dental/H10G.000 Health - Dental* | | |
| ***Product Name:*** | *Group Dental PPO* | | |
| ***Project Name/Number:*** | *Group Dental Products Project/0146GUA01-03* | | |

# Form Schedule

**Lead Form Number: GP-1-FFM-13-TN**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 1 | | Group Insurance Policy | GP-1-FFM-12-TN | POL | Initial | | 46.100 | TN GP-1-FFM-13-TN Group Insurance Policy v1 05-22-2013.pdf |
| 2 | | Certificate of Coverage | GC-EHB-FFM-13-TN | POLA | Initial | | 46.100 | TN GC-EHB-FFM-13-TN Certificate (v1 05-22-2013).pdf |
| 3 | | Certificate of Coverage | GC-SUPP-FFM-13-TN | POLA | Initial | | 46.100 | TN Greater of GC-SUPP-FFM-13-TN Certificate (v1 05-22-2013).pdf |
| 4 | | Schedule | SCH1-EHB-HIGH-FFM-TN | SCH | Initial | | 46.100 | TN SCH1-EHB-PPOHIGH-FFM-TN Schedule (v1 05-22-2013).pdf |
| 5 | | Schedule | SCH2-EHB-LOW-FFM-TN | SCH | Initial | | 46.100 | TN SCH2-EHB-PPOLOW-FFM-TN Schedule (v1 05-22-2013).pdf |
| 6 | | Schedule | SCH1-SUPP-HIGHORTH-FFM-TN | SCH | Initial | | 46.100 | TN SCH1-SUPP-PPOHIGHORTH-FFM-TN Schedule (v1 05-22-2013).pdf |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *GARD-129055732* | ***State Tracking #:*** | *H-130795* | ***Company Tracking #:*** | *0146GUA01-03* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *The Guardian Life Insurance Company of America* |
| ***TOI/Sub-TOI:*** | *H10G Group Health - Dental/H10G.000 Health - Dental* | | |
| ***Product Name:*** | *Group Dental PPO* | | |
| ***Project Name/Number:*** | *Group Dental Products Project/0146GUA01-03* | | |

**Lead Form Number: GP-1-FFM-13-TN**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 7 | | Schedule | SCH2-SUPP-HIGH-FFM-TN | SCH | Initial | | 46.100 | TN SCH2-SUPP-PPOHIGH-FFM-TN Schedule (v1 05-22-2013).pdf |
| 8 | | Schedule | SCH3-LOWORTH-FFM-TN | SCH | Initial | | 46.100 | TN SCH3-SUPP-PPOLOWORTH-FFM-TN Schedule (v1 05-22-2013).pdf |
| 9 | | Schedule | SCH4-LOW-FFM-TN | SCH | Initial | | 46.100 | TN SCH4-SUPP-PPOLOW-FFM-TN Schedule (v1 05-22-2013).pdf |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

**The Guardian** Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York

[1][ 7 Hanover Square, New York, New York 10004 ]

**POLICYHOLDER:** [2][ ABC Company ]

| **GROUP POLICY NUMBER** | **DELIVERED IN** | **POLICY DATE** |
|---|---|---|
| [2][ G-XXXXXXXX ] | [2][ TENNESSEE ] | [2][ January 1, 2013 ] |

**POLICY ANNIVERSARIES:** [2][ January first of each year, beginning in 2013 ]

**GUARDIAN AGREES** to pay benefits in accordance with, and subject to, the terms of this Policy. This promise is based on the Policyholder's Application.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of [2][ December 31, 2013 ] which is its date of issue.

[1][



Vice President, Group Products ]

**GROUP INSURANCE POLICY**

Providing

Dental Insurance

Please read this Policy carefully. If any error or omission is found, send full details with the number of the Policy to Guardian.

## TABLE OF CONTENTS

## GENERAL PROVISIONS

### Definitions

The terms shown below have the meanings shown below.

**Dental Insurance:** This term means any dental insurance provided by the Plan.

**Covered Person:** This term means an Employee or dependent insured by this Policy.

**Employee:** This term means a person: (1) who works for You or an associated company at Your or such company's place of business; and (2) whose income is reported for tax purposes using a W-2 or 1099 form. This term may also include a Qualified Retiree.

**Employer:** This term means the entity that purchased the Plan.

**Guardian, Our, Us** and **We:** These terms mean The Guardian Life Insurance Company of America.

**Policy:** This term means the Guardian group dental insurance Policy purchased by You.

**Qualified Retiree:** This term means an Employee who retires and is considered a Covered Person under this Plan.

**You** and **Your:** As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Employee.

### Incontestability

This Policy will be incontestable after two years from its Policy Date, except for non-payment of premiums.

This Policy may replace the group policy of another insurer. In that case, We may rescind this Policy based on misrepresentations made in Your or a Covered Person's signed application for up to two years from the Policy Date.

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred, or for a disability which starts, after his or her insurance has been in force for two years during his or her lifetime.

In the event a Covered Person's insurance is rescinded due to a fraudulent statement made in his or her application, We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Person will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Person's insurance Your part of the premium will be paid to You.

### Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Employees of that company like Your Employees. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each eligible Employee of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Employees, except those covered by You or another associated company as Employees on such date.

### Premiums

Premiums are payable by You. The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy.

We may change premium rates: (1) on the first day of any Policy month; (2) on any date the extent or terms of coverage for You are changed by amendment of this Policy; or (3) on any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements.

We must give You 31 days written notice of the premium rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

## Termination of Policy

A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

## Term of Policy – Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

You may cancel this Policy at any time by giving advance written notice, as determined by the Health Insurance Marketplace. We may cancel this Policy by giving You 31 days advance written notice.

## The Contract

The entire contract between You and Us consists of: (1) this Policy; (2) the Certificate(s) which describe(s) the insurance for which Covered Persons are insured; (4) any attached riders, schedule of benefits or amendments; and (5) Your application. In the event of a conflict, the Policy shall reign.

We can amend this Policy at any time without the consent of the insured, Employees or any other person having a beneficial interest in it: (1) upon written request made by You and agreed to by Us; (2) on any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or (3) on any date on which Our contractual relationship with any vendor supplying services or supplies with respect to this Policy changes.

If We amend this Policy, except upon request made by You, We must give You written notice of such change.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, policy or certificate is to be issued; (2) waive or alter any provisions of any contract or policy, or any of Our requirements; (3) bind Us by any statement or promise relating to the contract issued or to be issued; or (4) accept any information or representation which is not in a signed application.

## Clerical Error – Misstatements of Age

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated.

The age of an Employee, or any other relevant facts, may be found to have been misstated. If premiums are affected due to this, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by Us, or the amount of insurance, the true facts will be used to determine whether insurance is in force under the terms of this Policy, and in what amount.

## Statements

No statement will void the insurance under this Policy, or be used in defense of a claim unless in Your case, it is contained in the application signed by You or in the case of a Covered Person, it is contained in a written instrument signed by him or her.

All statements will be deemed representations and not warranties.

## Assignment

The Employees Certificate and his or her right to benefits under this Policy are not assignable.

Assignment or transfer of Your interest under this Policy will not bind Us without Our written consent.

## Employees Certificate

We will issue to You, for delivery to each insured Employee, a certificate of insurance. It will state the essential features of the insurance to which the Employee is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the certificate, a rider or revised certificate reflecting such amendment will be issued to You for delivery to affected Employees.

## Employee Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Employees.

## Claims of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Persons.

## Conformity with Law

If the provisions of this Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision is changed to conform with Our interpretation of the requirements of that law or regulation.

## New Entrants

Eligible new Employees may be added to the group originally insured in accordance with the terms of this Policy. If applicable, eligible new dependents may be added to the group of dependents originally insured in accordance with the terms of this Policy.

## Dental Claims Provisions

An Employee's right to make a claim for any dental benefits provided by this Policy is governed as follows:

**Notice:** The Employee must send Us written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts. This notice should include his or her name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

**Claim Forms:** We will furnish the Employee with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the injury or sickness that is the basis of the claim as proof of loss. The Employee must detail the nature and extent of the loss for which the claim is being made.

**Proof of Loss:** The Employee must send written proof to Our designated office within 90 days of the date of such loss.

**Late Notice or Proof:** We will not void or reduce the Employee claim if he or she cannot send Us notice and proof of loss within the required time. In that case, the Employee must send Us notice and proof as soon as reasonably possible.

**Payment of Benefits:**

We will pay all other dental benefits as soon as We receive written proof of loss.

Unless otherwise required by law or regulation, We pay all dental benefits to the Employee if he or she is living. If he or she is not living, We have the right to pay all dental benefits to one of the following the Employee: (1) estate; (2) spouse; (3) parents; (4) children; or (5) brothers and sisters.

**Legal Actions:** No legal action against this Policy shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against this Policy after three years from the date written proof of loss is required to be given.

**Workers' Compensation:** The dental benefits provided by this Policy are not in place of and do not affect requirements for coverage by Workers' Compensation.

## ATTACHED CERTIFICATES

If elected, the Certificate(s) shown below are added to and made part of this Policy.

Group Pediatric Dental Expense Coverage for Dependent Child Under the Age of 19
Certificate Form GC-EHB-FFM-13-TN

Group Dental Expense Coverage Certificate Form GC-SUPP-FFM-13-TN

Each Employee's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected, or other suitable documents approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by rider or amendments to this Policy.

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2
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2

**CERTIFICATE OF COVERAGE**

# THIS IS A LIMITED CERTIFICATE OF COVERAGE READ IT CAREFULLY

**The Guardian Life Insurance Company of America**
[2] [ 7 Hanover Square
New York, New York 10004
(xxx) xxx-xxxx ]

The group dental expense coverage described in this Certificate is attached to the group Policy effective [1] [ January 1, 2013 ]. This Certificate replaces any Certificate previously issued under the Plan or under any other Plan providing similar or identical benefits issued to the Policyholder by Guardian.

## GROUP PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS EXPENSE COVERAGE

## FOR COVERED PERSONS UNDER THE AGE OF 19

Guardian certifies that the Covered Person(s) named below is/are entitled to the benefits provided by Guardian described in this Certificate. However, the Covered Person(s) must: (a) satisfy all of this Plan's eligibility and effective date requirements; and (b) all required premium payments have been made by or on behalf of the Covered Person(s).

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

| | |
|---|---|
| Policyholder: | Group Policy Number: |
| Employee Name: | |
| Dependent(s) under age 19: | |
| Certificate Number: | Effective Date: |

**Policyholder:** [1] [ ABC Company ]
**Group Policy Number:** [1] [ G-000123456 ]

[2] [ **The Guardian** Life Insurance Company of America

SPECIMEN

Vice President, Group Products ]

## TABLE OF CONTENTS

## DEFINITIONS

This section defines certain terms appearing in Your Certificate.

**Anterior Teeth:** This term means the incisor and cuspid teeth. These are the teeth located in front of the bicuspids (pre-molars).

**Appliance:** This term means any dental device other than a Dental Prosthesis.

**Benefit Year:** This term means a 12 month period which starts on [1][ January 1 ] and ends on [1][ December 31 ] of each year.

**Covered Dental Specialty:** This term means any group of procedures which falls under one of the following categories, whether performed by a specialist Dentist or a general Dentist: (1) restorative/prosthodontic services; (2) endodontic services; (3) periodontic services; (4) oral surgery; and (5) pedodontics.

**Covered Person:** This term means Your covered dependents under the age of 19.

**Dental Prosthesis:** This term means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of: (1) abutment crowns; (2) inlays and onlays; (3) bridge pontics; (4) complete and immediate dentures; (5), partial dentures; and (6) unilateral partials. It also includes all types of: (a) crowns; (b) veneers; (c) implants; and (d) posts and cores.

**Dentist:** This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or certificate and covered by this Plan.

**Eligibility Date:** For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan.

**Emergency Treatment:** This term means bona fide emergency services which: (1) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort or to prevent the imminent loss of teeth; and (2) are covered by this Plan.

**Employee:** This term means a person who works no less than 20 hours per week for the Employer and whose income is reported for tax purposes using a W-2 form.

**Employer:** This term means [1][ ABC Company, Inc ].

**Injury:** This term means: (1) all damage to a Covered Person's mouth due to an accident which occurs while he or she is covered by this Plan; and (2) all complications arising from that damage. But, the term does not include damage to teeth, Appliances or dental prostheses which results solely from chewing or biting food or other substances.

**Non-Preferred Provider:** This term means a Dentist or dental care facility that is not under contract with DentalGuard Preferred and/or DentalGuard Alliance as a Preferred Provider.

**Orthodontic Treatment:** This term means the movement of one or more teeth by the use of Active Appliances. It includes: (1) treatment plan and records, including initial, interim and final records; (2) periodic visits; (3) limited Orthodontic Treatment, interceptive Orthodontic Treatment and comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances; and (4) orthodontic retention, including any and all necessary fixed and removable Appliances and related visits.

**Preferred Provider:** This term means a Dentist or dental care facility that is under contract with DentalGuard Preferred and/or DentalGuard Alliance as a Preferred Provider.

**Payment Rate:** This term means the percentage rate that this Plan pays for covered charges for covered services.

**Plan:** This term means the group dental expense coverage described in the Policy and this Certificate.

**Posterior Teeth:** This term means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

**Proof of Claim:** This term means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

**Qualified Retiree:** This term means an Employee who retires and is considered a Covered Person under this Plan.

**We, Us, Our** and **Guardian:** These terms mean The Guardian Life Insurance Company of America.

**You** or **Your:** These terms mean the insured Employee.

## GENERAL PROVISIONS

### Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Policy or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

### Incontestability

The Plan is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred, after such insurance has been in force for two years during his or her lifetime.

If the Plan replaces a plan Your Employer had with another insurer, We may rescind the Plan based on misrepresentations made by the Employer or an Employee signed application for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to a fraudulent statement made in Your application, We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

### Statements

No statement will avoid the insurance under this plan, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him or her; or (b) in the case of a covered person, it is contained in a written instrument signed by him or her, a copy of which has been furnished to the covered person or his or her beneficiary.

Absent fraud, all statements made by an applicant, group policyholder, or insured are considered to be representations and not warranties.

## CLAIMS PROVISIONS

Your right to make a claim for dental benefits provided by the Policy is governed as shown below.

### Notice

You must send Us written notice of an Injury or sickness for which a claim is being made within 20 days of the date the Injury occurs or the sickness starts. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

### Claim Forms

We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the Injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

### Proof of Loss

You must send written proof to Our designated office within 90 days of the date of such loss.

### Late Notice of Proof

We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible.

### Payment of Benefits

We will pay all dental benefits when We receive written proof of loss.

Unless otherwise required by law or regulation, We pay all dental benefits to You. If You are not living, We have the right to pay all dental benefits to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

When proof of loss is filed, You or any other payee may direct Us, in writing, to pay dental benefits to the Provider who furnished the covered service for which benefits became payable. We may honor such direction at Our option. However, We cannot require that a particular provider furnish such care. You or any other payee may not assign the right to take legal action under the Policy to such provider.

### Legal Actions

No legal action against the Policy shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against the Policy after three years from the date written proof of loss is required to be given.

### Workers' Compensation

The dental benefits provided by the Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

# ELIGIBILITY FOR PEDIATRIC DENTAL

# ESSENTIAL HEALTH BENEFITS EXPENSE COVERAGE

## Eligible Employee

Subject to the conditions of eligibility set forth below, and all of the other conditions of this Plan, You are an eligible Employee if:

- You have been deemed eligible by Your Employer; and
- Your Employer's eligibility standards are consistent with the Health Insurance Marketplace rules.

## Conditions of Eligibility

**Enrollment Requirement:** We will not cover You until You enroll Your Dependent Children in this Plan and agree to make the required payments.

**Multiple Employment:** If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple dental coverage under this Plan.

## Eligible Dependents

Your eligible dependents are Your Dependent Children who are under the age of 19.

Your "dependent children" include Your legally adopted children and Your step-children. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

## When Coverage Starts

The date Your coverage is scheduled to start is shown on the face page of this Certificate of Coverage. You must elect to enroll and agree to make the required payments before Your coverage will start.

## When Coverage Ends

Your coverage will end on the first of the following dates:

- The day You stop being an eligible Employee as defined by Your Employer.
- The last day of the period for which required payments are made for this Plan.
- The last day of the month in which your Dependent Child turns 19 years of age.

## PEDIATRIC DENTAL EXPENSE BENEFITS

This coverage will pay for pediatric dental essential health benefits expenses as set forth by the Health Insurance Marketplace. We pay benefits for covered charges incurred by a Covered Person under the age of 19. What We pay and terms for payment are explained below.

This Certificate includes form(s) [5][ SCH1-EHB-PPOHIGH-FFM-TN ], which are the Plan's Schedule of Benefits.

## [6][ DentalGuard Preferred [4][ and DentalGuard Alliance ] -This Plan's Dental Preferred Provider Organization

This Plan is designed to provide high quality dental care while controlling the cost of such care. To do this, this Plan encourages a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with Guardian's dental preferred provider organizations (PPOs), which [6][ [7][ is ] called DentalGuard Preferred [4][ and DentalGuard Alliance] ].

The dental PPO is made up of Preferred Providers in a Covered Person's geographic area. Use of the dental PPO is voluntary. A Covered Person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers at any time. When You enroll in this Plan, You and Your covered dependents receive: (1) a dental plan ID card; and (2) information about current Preferred Providers.

This Plan usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider.

But, this Plan's Payment Limits differ based upon whether a Covered Person uses the services of a Preferred Provider or a Non-Preferred Provider. A Covered Person will usually be left with less out-of-pocket expense when a Preferred Provider is used.

A Covered Person must present his or her ID card when he or she uses a Preferred Provider. Most Preferred Providers prepare necessary claim forms for the Covered Person, and submit the forms to Us. We send the Covered Person an explanation of this Plan's benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Plan. Please read this Plan carefully for specific benefit levels, deductibles Payment Rates and service Payment Limits.

A Covered Person may call Guardian at the number shown on his or her ID card should he or she have any questions about this Plan.

## Covered Charges

Whether a Covered Person uses the services of a Preferred Provider or a Non-Preferred Provider, covered charges are the charges listed in the fee schedule the Preferred Provider has agreed to accept as payment in full, for the dental services listed in this Plan's List of Covered Dental Services.

To be covered by this Plan, a service must be: (1) necessary; (2) appropriate for a given condition; and (3) included in the List of Covered Dental Services.

We may use the professional review of a Dentist to determine the appropriate benefit for a dental procedure or course of treatment.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed: (1) prior to; (2) at the same time; or (3) at a later date. For benefit purposes under this Plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedures scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, We will only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred while a person is covered by this Plan.

A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is first prepared. A covered charge for any other Dental Prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened.

All other covered charges are incurred on the date the services are furnished.

## Alternate Treatment

If more than one type of service can be used to treat a dental condition, We have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by Us. For example, in the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding amalgam filling benefit.

## Proof of Claim

The Covered Person or his or her Dentist must provide Us with proof that is acceptable to Us. This proof may, at Our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document Proof of Claim and support the necessity of the proposed treatment. If We do not receive the necessary proof, We may pay no benefits, or minimum benefits. But, if We receive the necessary proof within 15 months of the date of service, We will redetermine the Covered Person's benefits based on the new proof.

## Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the Covered Person's Dentist should send Us a treatment plan before he or she starts. This must be done on a form acceptable to Us. The treatment plan must include: (1) a list of the services to be done, using the American Dental Association Nomenclature and codes; (2) the itemized cost of each service; and (3) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to Us.

We review the treatment plan and estimate what We will pay. We will send the estimate to the Covered Person and his or her Dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to Us, We have the right to base Our benefit payments on treatment appropriate to the Covered Person's condition using accepted standards of dental practice.

The Covered Person and his or her Dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what We will pay. It tells the Covered Person, and his or her Dentist, in advance, what We would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (1) the services being performed as proposed and while the person is covered; and (2) the benefit provisions, and all of the other terms of this Plan.

Emergency Treatment, oral exams, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We will not deny or reduce benefits if pre-treatment review is not done. But, what We pay will be based on the availability and submission of Proof of Claim.

## Benefits from Other Sources

Other plans may furnish benefits similar to the benefits provided by this Plan. For instance, You may be covered by this Plan and a similar plan through Your spouse's employer. You may also be covered by this Plan and a medical plan. In such instances, We coordinate Our benefits with the benefits from that other plan. We do this so that no one gets more in benefits than the charges he or she incurs. Read Coordination of Benefits to see how this works.

## Waiting Periods for Certain Services

During the first 24 months a person is covered by this Plan, We will not cover charges for the following services:

- Group IV services.

Charges We do not cover as shown above are not covered charges under this Plan, and cannot be used to meet this Plan's deductibles.

The Waiting Period will be waived with proof of 12 consecutive months of prior group coverage with no lapse in coverage.

## How We Pay Benefits for Services

**Deductible:** The Benefit Year deductible is shown in the Schedule of Benefits. Each Covered Person must have covered charges which exceed the deductible before We pay him or her any benefits for such charges. These charges must be incurred while he or she is covered.

**Payment of Benefits:** Once the deductible is met, We pay benefits for covered charges above that amount at the applicable Payment Rates for the rest of that Benefit Year. This Plan's Payment Rates are shown in the Schedule of Benefits.

**After This Coverage Ends:** We do not pay for charges incurred after a person's coverage ends.

## Limitations

**Teeth Lost , Extracted or Missing Before A Covered Person Becomes Covered By This Plan:** A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan.

## Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least 60 months old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.

- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.

## LIST OF COVERED DENTAL SERVICES

The services covered by this Plan are named in this list. In order to be covered, the service must be furnished by, or under the direct supervision of a Dentist and the service must be usual and necessary treatment for a dental condition.

### Group I Services

### (Diagnostic & Preventive)

**Prophylaxis and Fluorides**

Prophylaxis (Adult prophylaxis covered age 12 and older): Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application: Limited to Covered Persons under age 19 and to two treatments in any twelve consecutive month period.

**Office Visits, Evaluations and Examination**

Comprehensive oral evaluation – limited to once every 36 consecutive months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment limited to a total of one in

any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

**Space Maintainers**

Space Maintainers: Limited to initial Appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral.
- Fixed - bilateral.
- Removable - unilateral.
- Removable - bilateral.

Recementation of space maintainer performed more than 12 months after the initial insertion.

Removal of fixed space maintainer is considered once per quadrant or arch (as applicable) per lifetime.

**Radiographs**

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 6 consecutive month period.

Intraoral periapical or occlusal images- single images.

**Dental Sealants**

Dental Sealants or Preventive Resin Restoration, permanent molar teeth only: Topical application of sealants is limited to the unrestored, caries free, surfaces of permanent molar teeth. Limited to one treatment, per tooth, in any 36 consecutive month period.

## Group II Services

## (Basic)

**Restorative Services**

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 60 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

**Diagnostic Services**

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

**Other Services**

Injectable antibiotics needed solely for treatment of a dental condition.

## Group III Services

## (Major)

**Group III Restorative Services**

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations.

Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic, when done in connection with a covered surgical placement of an implant on the same tooth.

- Abutment supported crown.
- Implant supported crown.

- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous arch.
- Dental implant supported connecting bar.
- Prefabricated abutment.
- Custom abutment.

Implant services: Allowance includes the treatment plan, local anesthetic and post-surgical care. The number of implants We cover is limited to the number of teeth extracted in the same area while the person is covered under this Plan. Also, see the Special Limitations section and Exclusions.

- Surgical placement of implant body, endosteal implant.
- Surgical placement, eposteal implant.
- Surgical placement transosteal implant.

Other implant services:

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site: Limited to once per tooth, per lifetime.
- Radiographs/surgical implant index: Limited to once per arch in any 24 month period.
- Repair implant supported prosthesis.
- Repair implant abutment.
- Implant removal.

**Prosthodontic Services**

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.

- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Lower, resin base, including any conventional clasps, rests and teeth.
- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

**Crown and Prosthodontic Restorative Services**

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture rebase, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

**Other Services**

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under Other Surgical Procedures.

Detailed and extensive oral evaluations – problem focused, by report

**Endodontic Services**

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

- Root canal treatment Root canal retreatment Limited to once per tooth, per lifetime.
- Treatment of root canal obstruction, no surgical access.
- Incomplete endodontic therapy, inoperable or fractured tooth.
- Internal root repair of perforation defects.
- Apexification: Limited to a maximum of three visits.
- Apicoectomy: Limited to once per root, per lifetime.
- Root amputation: Limited to once per root, per lifetime.
- Retrograde filling: Limited to once per root, per lifetime.
- Hemisection, including any root removal: Once per tooth.

**Periodontal Services**

Periodontal maintenance: Limited to a total of four periodontal maintenance or prophylaxis in any twelve month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis and Fluorides in Group I Services.

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once per lifetime.

**Periodontal Surgery**

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

**Periodontal Surgery Related**

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

**Non-Surgical Extractions**

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

**Surgical Extractions**

Allowance includes the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan**.

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

**Other Oral Surgical Procedures**

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Vestibuloplasty.

Tooth reimplantation.

## Group IV Services

## (Orthodontics)

**Orthodontic Services**

Prior authorization is required for Orthodontic Services. Orthodontic Services are covered when needed to due to severe, dysfunctional, handicapping malocclusion.

- Orthodontic records includes exams, x-rays, diagnostic photographs, diagnostic casts or cephalometric films.
- Limited Orthodontic Treatment, interceptive Orthodontic Treatment, or comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances and periodic visits. Minor treatment to control harmful habits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits: limited to initial Appliance(s) only.

A covered charge for Orthodontic Treatment is incurred on the date the Active Orthodontic Appliance is first placed.

**Treatment Plan**

A treatment plan should always be sent to us before Orthodontic Treatment starts.

**How We Pay Benefits for Orthodontic Services**

Using the Covered Person's original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Plan.

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered by this Plan. Based on the original treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fix and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement

or repair of orthodontic appliances damaged due to the neglect of the patient; and (e) orthodontic treatment started before the member was eligible for orthodontic benefits under this Plan. Whether or not a charge is based on a discounted fee, it will be counted toward a Covered Person's orthodontic lifetime payment limited under this Plan.

## CONTINUATION RIGHTS

### Coordination Between Continuation Sections

A Covered Person may be eligible to continue his or her group dental coverage under more than one Continuation Rights section at the same time. If he or she chooses to continue his or her group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

A Covered Person continuing coverage under more than one continuation section: (1) will not be entitled to duplicate benefits; and (2) will not be subject to the premium requirements of more than one section at the same time.

### Uniformed Services Continuation Rights

If You enter or return from military service, You may be able to continue coverage under this Plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If Your group dental coverage under this Plan would otherwise end because You enter into active military service, You may elect to continue such coverage for yourself and Your eligible dependents in accordance with the provisions of USERRA.

Group dental coverage may be continued while You are in the military for up to 24 months starting on the date of absence from work. Continued coverage will end if You fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact Your Employee for details about this continuation provision, including required premium payments.

### COBRA Continuation Rights
### Employee and Dependent

**Important Notice:** The Federal Continuation Rights section may not apply to Your Employer's plan. You must contact Your Employer's to find out if Your Employer's is subject to the Federal continuation rights requirement. If Your Employer's is subject to that requirement, the Federal Continuation Rights section applies to You.

**Qualified Continuee:** Under this section, the term "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group dental coverage as: (1) an active Employee or Qualified Retiree; (2) the spouse of an active Employee Qualified Retiree; or (3) the dependent child of an active Employee Qualified Retiree. A child born to, or adopted by, an active Employee Qualified Retiree during a continuation provided by this section is also a qualified continuee. Any other person who would otherwise become eligible for group dental coverage during a continuation provided by this section is not a qualified continuee.

**If an Employee's Group Dental Coverage Ends:** If Your group dental coverage would otherwise end due to Your termination of employment or reduction of work hours, You may elect to continue such coverage for up to 18 months, if You were not terminated due to gross misconduct.

The continuation: (1) may cover You or any other qualified continuee; and (2) is subject to When Continuation Ends.

**Extra Continuation for Disabled Qualified Continuees:** If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group dental coverage would otherwise end due to Your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give Your Employer written proof of Social Security's determination of his or her disability as described in The Qualified Continuee's Responsibilities. If, during the extra 11 month continuation period, the qualified continuee is determined to be no longer disabled

under the Social Security Act, he or she must notify Your Employer within 30 days of such determination and continuation will end, as explained in When Continuation Ends.

This extra 11 month continuation is subject to When Continuation Ends.

An additional 50% of the total premium charge also may be required from the qualified continuee and all qualified continuees who are members of the disabled qualified continuee's family by Your Employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

**Special Continuance for Retired Employees and Their Dependents:** If Your group dental coverage would otherwise end due to a bankruptcy proceeding under Title 11 of the United States Code involving the Employer, You may elect to continue such benefits, provided that: (1) You are or become a retired Employee on or before the date group dental coverage would otherwise end; and (2) You and Your dependents were covered for group dental coverage under this Plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for Your lifetime. After Your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for You and Your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If You die before the bankruptcy proceeding under Title 11 of the United States Code, Your surviving spouse and dependent children may elect to continue group dental coverage on their own behalf, provided they were covered on the day before such proceeding. The continuation can last for Your surviving spouse's lifetime.

This special continuance starts on the later of (1) the date of the proceeding under Title 11; or (2) the day after the date group dental coverage would otherwise have ended. It ends as described in When Continuation Ends, except that a person's entitlement to Medicare will not end such continuance.

**If You Die While Covered:** If You die while covered, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. The continuation can last for up to 36 months, subject to When Continuation Ends.

**If Your Marriage Ends:** If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. The continuation can last for up to 36 months, subject to When Continuation Ends.

**If a Dependent Child Loses Eligibility:** If a dependent child's group dental coverage would otherwise end due to his or her loss of dependent eligibility as defined in this Plan, other than Your coverage ending, he or she may elect to continue such coverage. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to When Continuation Ends.

**Concurrent Continuations:** If a dependent elects to continue his or her group dental coverage due to Your termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period he or she becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

**Special Medicare Rule:** If You become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after Your later termination of employment or reduction of work hours, will be the longer of: (1) 18 months (29 months if there is a disability extension) from Your termination of employment or reduction of work hours; or (2) 36 months from the date of Your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

**The Qualified Continuee's Responsibilities:** A person eligible for continuation under this section must notify [9A][ ADP ] [9B][ Your Employer ], in writing, of: (1) Your legal divorce or separation from Your spouse; (2) the loss of dependent eligibility, as defined in this Plan, of a covered dependent child; (3) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (4) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such

continuation; and (5) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to [9A][ ADP ] [9B][Your Employer ] by a qualified continuee within 60 days of the latest of: (1) the date on which an event that would qualify a person for continuation under this section occurs; (2) the date on which the qualified continuee loses (or would lose) coverage under this Plan as a result of the event; or (3) the date the qualified continuee is informed of the responsibility to provide notice to [9A][ ADP ] [9B][ Your Employer ]and this Plan's procedures for providing such notice.

Notice of a disability determination must be given to [9A][ ADP ] [9B][ Your Employer ] by a qualified continuee within 60 days of the latest of: (1) the date of the Social Security Administration determination; (2) the date of the event that would qualify a person for continuation; (3) the date the qualified continuee loses or would lose coverage; or (4) the date the qualified continuee is informed of the responsibility to provide notice to [9A][ ADP ] [9B][ Your Employer ] and this Plan's procedures for providing such notice. But, such notice must be given before the end of the first 18 months of continuation coverage.

**Your Employer's Responsibilities:** A qualified continuee must be notified, in writing, of: (1) his or her right to continue this Plan's group dental coverage; (2) the premium he or she must pay to continue such coverage; and (3) the times and manner in which such payments must be made.

Your Employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (1) Your death; or (2) termination of employment (other than for gross misconduct) or reduction in hours of employment; or (3) Medicare entitlement; or (4) if You are a retired Employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to Your Employer. Upon receipt of notice of a qualifying event from Your Employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this Plan's group dental coverage no later than 14 days after receipt of notice.

If Your Employer is also the plan administrator, in the case of a qualifying event for which the Employer must give notice to the plan administrator, Your Employer must provide notice to a qualified continuee of the right to continue this Plan's group dental coverage within 44 days of the qualifying event.

If Your Employer determines that a person is not eligible for continued group dental coverage under this Plan, [9A][ ADP ] [9B][ Your Employer ] must notify him or her with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group dental coverage under this Plan is cancelled prior to the maximum continuation period, [9A][ ADP ] [9B][Your Employer ]must notify the qualified continuee as soon as practical following determination that the continued group dental coverage shall terminate.

**Your Employer's Liability:** Your Employer will be liable for the qualified continuee's continued group dental coverage to the same extent as, and in place of, Us, if [9A][ ADP ] [9B][ Your Employer ] fails: (1) to remit a qualified continuee's premium payment to Us on time, causing the qualified continuee's continued group dental coverage to end; or (2) to notify the qualified continuee of his or her continuation rights as described above.

**Election of Continuation:** To continue his or her group dental coverage, the qualified continuee must give [9A][ ADP ] [9B][Your Employer ] written notice that he or she elects to continue. This must be done by the later of: (1) 60 days from the date a qualified continuee receives notice of his or her continuation rights from [9A][ ADP ] [9B][ Your Employer ] as described above; or (2) the date group dental coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to [9A][ ADP] [9B][ Your Employer ], by the qualified continuee, in advance, at the times and in the manner specified by [9A][ ADP ] [9B][Your Employer ]. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group dental coverage had the qualified continuee stayed covered under the group Plan on a regular basis. It includes any amount that would have been paid by Your Employer. Except as explained in Extra Continuation For Disabled Qualified Continuees, an additional charge of two percent of the total premium charge may also be required by [9A][ ADP ] [9B][ Your Employer ].

If the qualified continuee fails to give [9A][ ADP ] [9B][ Your Employer ] notice of his or her intent to continue, or fails to pay any required premium in a timely manner, he or she waives his or her continuation rights.

**Grace In Payment of Premium:** A qualified continuee's premium payment is timely if, with respect to the first payment after he or she elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made in an amount that is not significantly less than the amount the Plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid, unless [9A][ ADP ] [9B][ Your Employer ] notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to [9A][ ADP ] [9B][ Your Employer ].

**When Continuation Ends:** A qualified continuee's continued group dental coverage ends on the first of the following:

- With respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental coverage would otherwise end;
- With respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (1) the end of the 29 month period which starts on the date the group dental coverage would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- The date Your Employer ceases to provide any group dental coverage to any Employee;
- The end of the period for which the last premium payment is made;
- The date, after the date of election, a qualified continuee becomes covered under any other group dental coverage which does not contain any pre-existing condition exclusion or limitation affecting him or her;
- The date, after the date of election, the qualified continuee becomes entitled to Medicare; or
- With respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group dental coverage would otherwise end.

## Your Right to Continue Dental Expense Coverage During a Family Leave of Absence

**Important Notice:** This section may not apply to Your Employer's plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

**If Your Coverage Would End:** Your dental expense coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a serious injury or illness arising out of the fact that Your spouse, child, parent or next of kin who is a covered servicemember is on active duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

**When Continuation Ends:** Continued coverage will end on the earliest of the following:

- The date You return to Active Work.
- The end of a total leave period of 26 weeks in one 12 month period, if You care for a covered servicemember. This 26 week total leave period applies to all leaves granted to You under this section for all reasons.
- The end of a total leave period of 12 weeks in: (1) any later 12 month period, if You care for a covered servicemember; or (2) any 12 month period in any other case.
- The date on which Your coverage would have ended had You not been on leave.

- The end of the period for which premium has been paid.

**Definitions:** As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered servicemember, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

## COORDINATION OF BENEFITS

**Purpose:** When a Covered Person has coverage for dental expenses under more than one plan, this section allows this Plan to coordinate what it pays with what other plans pay. This is done so that the Covered Person does not collect more in benefits than he or she incurs in charges.

### Definitions

For the purposes of this section, the following terms are defined as:

**Allowable Expense:** This term means any necessary, reasonable, and customary item of dental expense that is covered, at least in part, by any of the plans which cover the person. This includes: (1) deductibles; (2) coinsurance; and (3) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (1) second surgical opinions; (2) precertification of admissions; and (3) preferred provider arrangements.
- If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has

contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

**Claim:** This term means a request that benefits of a plan be provided or paid.

**Claim Determination Period:** This term means a calendar year. It does not include any part of a year during which a person has no coverage under this Plan, or before the date this section takes effect.

**Closed Panel Plan:** This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides dental benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

**Coordination of Benefits:** This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

**Custodial Parent:** This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Group-Type Contracts:** This term means contracts: (1) which are not available to the general public; and (2) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.

**Plan:** This term means any of the following that provides benefits or services for dental care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) medical benefits under group or individual automobile contracts; and (5) governmental benefits, except Medicare, as permitted by law.

This term does not include: (1) individual or family insurance; (2) closed panel or other individual coverage, except for group-type coverage; (3) school accident type coverage; or (4) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

**Primary Plan:** This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

**Secondary Plan:** This term means a plan that is not a primary plan.

**This Plan:** This term means the group dental benefits provided under this group Plan.

## Right to Receive and Release Needed Information

Certain facts about dental coverage and services are needed to apply these rules and to determine benefits payable under this Plan and other plans. This Plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this Plan and other plans which cover the person claiming benefits. This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must provide any facts it needs to apply these rules and determine benefits payable.

## Facility of Payment

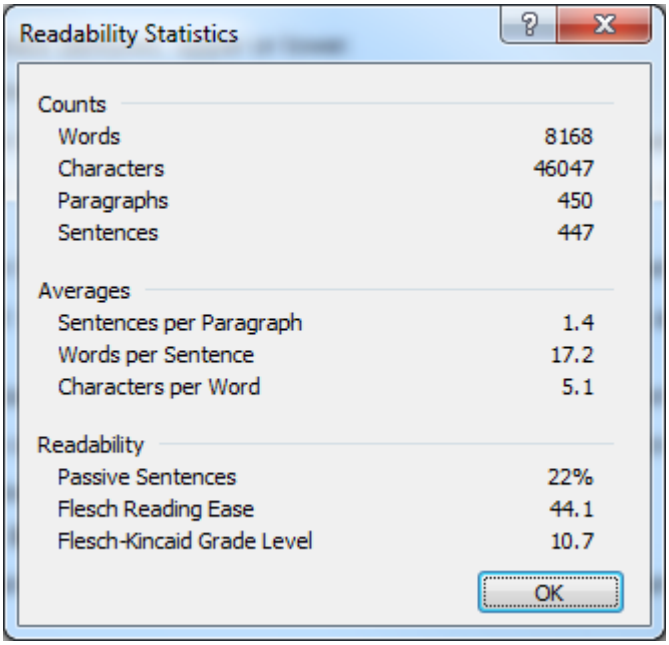
A payment made under another plan may include an amount that should have been paid by this Plan. If it does, this Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this Plan. This Plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

## Right of Recovery

If the amount of the payments made by this Plan is more than it should have paid under this section, it may recover the excess: (1) from one or more of the persons it has paid or for whom it has paid; or (2) from any other person or organization that may be responsible for benefits or services provided for the Covered Person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.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Flesch Reading Ease 44.1
Flesch-Kincaid Grade Level 10.7
OK

**CERTIFICATE OF COVERAGE**

# THIS IS A LIMITED CERTIFICATE OF COVERAGE READ IT CAREFULLY

**The Guardian Life Insurance Company of America**
[2][ 7 Hanover Square
New York, New York 10004
(xxx) xxx-xxxx ]

The group dental expense coverage described in this Certificate is attached to the group Policy effective [1][ January 1, 2011. ] This Certificate replaces any Certificate previously issued under the Plan or under any other Plan providing similar or identical benefits issued to the Policyholder by Guardian.

## GROUP DENTAL EXPENSE COVERAGE

## INCLUDING PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT SERVICES

Guardian certifies that the Employee named below is entitled to the benefits provided by Guardian described in this Certificate. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; and (b) all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

| | |
|---|---|
| Policyholder : | Group Policy Number: |
| Issued To: | |
| Certificate Number: | Effective Date: |

**Policyholder:** [1][ ABC Company ]
**Group Policy Number:** [1][ G-000123456 ]

[2][ **The Guardian** Life Insurance Company of America



Vice President, Group Product ]

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## DEFINITIONS

This section defines certain terms appearing in Your Certificate.

**Anterior Teeth:** This term means the incisor and cuspid teeth. These are the teeth located in front of the bicuspids (pre-molars).

**Appliance:** This term means any dental device other than a Dental Prosthesis.

**Benefit Year:** This term means a 12 month period which starts on [1][ January 1 ] and ends on [1][ December 31 ] of each year.

**Covered Dental Specialty:** This term means any group of procedures which falls under one of the following categories, whether performed by a specialist Dentist or a general Dentist: (1) restorative/prosthodontic services; (2) endodontic services; (3) periodontic services; (4) oral surgery; and (5) pedodontics.

**Covered Family:** This term means You and those of Your dependents who are covered by this Plan.

**Covered Person:** This term means You, if You are covered by this Plan, and any of Your covered dependents.

**Dental Prosthesis:** This term means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of: (1) abutment crowns; (2) inlays and onlays; (3) bridge pontics; (4) complete and immediate dentures; (5), partial dentures; and (6) unilateral partials. It also includes all types of: (a) crowns; (b) veneers; (c) implants; and (d) posts and cores.

**Dentist:** This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or certificate and covered by this Plan.

**Eligibility Date:** For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan.

**Emergency Treatment:** This term means bona fide emergency services which: (1) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort or to prevent the imminent loss of teeth; and (2) are covered by this Plan.

**Employee:** This term means a person who works no less than 20 hours per week for the Employer and whose income is reported for tax purposes using a W-2 form.

**Employer:** This term means [1][ ABC Company, Inc ].

**Injury:** This term means: (1) all damage to a Covered Person's mouth due to an accident which occurs while he or she is covered by this Plan; and (2) all complications arising from that damage. But, the term does not include damage to teeth, Appliances or dental prostheses which results solely from chewing or biting food or other substances.

**Late Entrant:** This term means a person who [4][, other than a child less than age 3 ]: (1) becomes covered by this Plan more than 31 days after he or she is eligible; or (2) becomes covered again, after his or her coverage lapsed because he or she did not make required payments. [4][ For a child less than age 3 this term means such child who (1) becomes covered by this Plan more than 31 days after such child's third birthday; or (2) becomes covered again, after his or her coverage lapsed because the required payments for his or her coverage were not made. ]

**Non-Preferred Provider:** This term means a Dentist or dental care facility that is not under contract with DentalGuard Preferred [5][ and/or DentalGuard Alliance ] as a Preferred Provider.

**Orthodontic Treatment:** This term means the movement of one or more teeth by the use of Active Appliances. It includes: (1) treatment plan and records, including initial, interim and final records; (2) periodic visits; (3) limited Orthodontic Treatment, interceptive Orthodontic Treatment and comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances; and (4) orthodontic retention, including any and all necessary fixed and removable Appliances and related visits.

**Payment Limit:** This term means the maximum amount this Plan pays for covered charges for covered services during a Benefit Year.

**Payment Rate:** This term means the percentage rate that this Plan pays for covered charges for covered services.

**Plan:** This term means the group dental expense coverage described in the Policy and this Certificate.

**Posterior Teeth:** This term means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

**Preferred Provider:** This term means a Dentist or dental care facility that is under contract with DentalGuard Preferred [5][ and/or DentalGuard Alliance ] as a Preferred Provider.

**Proof of Claim:** This term means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

**Qualified Retiree:** This term means an Employee who retires and is considered a Covered Person under this Plan.

**Rollover:** This term means the dollar amount which will be added to a Covered Person's Rollover Account when he or she receives benefits in a Benefit Year that do not exceed the Rollover Threshold.

**Rollover Account:** This term means the amount of a Covered Person's accrued Rollover.

**Rollover Account Maximum:** This term means the maximum amount of Rollover that a Covered Person can store in his or her Rollover Account.

**Rollover Threshold:** This term means the maximum amount of benefits that a Covered Person can receive during a Benefit Year and still be entitled to receive a Rollover.

**Service Payment Limit:** This term means the maximum amount this Plan pays for covered charges for a particular covered service each time it is performed. The services We cover and the Service Payment Limit for each service are shown in this Plan's List of Covered Dental Services.

**We, Us, Our** and **Guardian:** These terms mean The Guardian Life Insurance Company of America.

**You** or **Your:** These terms mean the insured Employee.

## GENERAL PROVISIONS

### Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Policy or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

### Incontestability

The Plan is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred, after such insurance has been in force for two years during his or her lifetime.

If the Plan replaces a plan Your Employer had with another insurer, We may rescind the Plan based on misrepresentations made by the Employer or an Employee signed application for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to a fraudulent statement made in Your application We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

## DENTAL CLAIMS PROVISIONS

Your right to make a claim for dental benefits provided by the Policy is governed as shown below.

### Notice

You must send Us written notice of an Injury or sickness for which a claim is being made within 20 days of the date the Injury occurs or the sickness starts. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

### Claim Forms

We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the Injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

### Proof of Loss

You must send written proof to Our designated office within 90 days of the date of such loss.

### Late Notice of Proof

We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible.

### Payment of Benefits

We will pay all dental benefits when We receive written proof of loss.

Unless otherwise required by law or regulation, We pay all dental benefits to You. If You are not living, We have the right to pay all dental benefits to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

When proof of loss is filed, You or any other payee may direct Us, in writing, to pay dental benefits to the Provider who furnished the covered service for which benefits became payable. We may honor such direction at Our option. However, We cannot require that a particular provider furnish such care. You or any other payee may not assign the right to take legal action under the Policy to such provider.

### Legal Actions

No legal action against the Policy shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against the Policy after three years from the date written proof of loss is required to be given.

### Workers' Compensation

The dental benefits provided by the Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

## ELIGIBILITY FOR DENTAL COVERAGE

### Eligible Employee

Subject to the conditions of eligibility set forth below, and all of the other conditions of this Plan, You are an eligible Employee if:

- You have been deemed eligible by Your Employer; and
- Your Employer's eligibility standards are consistent with Health Insurance Marketplace rules.

### Conditions Of Eligibility

**Enrollment Requirement:** We will not cover You until You enroll in this Plan and agree to make the required payments.

**Multiple Employment:** If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple dental coverage under this Plan.

### When Employee Coverage Starts

The date Your coverage is scheduled to start is shown on the face page of this Certificate of Coverage. You must elect to enroll and agree to make the required payments before Your coverage will start.

### When Employee Coverage Ends

Your coverage will end on the first of the following dates:

- The day You stop being an eligible employee as defined by Your Employer.
- The last day of the period for which required payments are made for this Plan.

## DEPENDENT COVERAGE

### Eligible Dependents For Dental Expense Coverage

Your eligible dependents are Your: (a) spouse and; (b) Your dependent children who are under age 26.

### Adopted Children and Step-Children

Your "dependent children" includes Your legally adopted children and Your step-children. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

### Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force. And We exclude any dependent who is covered by this Plan as an Employee.

A child may be an eligible dependent of more than one Employee who is covered under this Plan. In that case, the child may be covered for dependent dental care benefits by only one Employee at a time.

### Handicapped Children

You may have a child: (a) with a mental or physical handicap or developmental disability and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent dental benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she is unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon You for most of his or her support and maintenance.
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

The child's coverage ends when Your coverage ends.

### [16][ Waiver of Dental Late Entrants Penalty

If You initially waived dental coverage for Your dependents under this Plan because they were covered under another group dental plan and You now elect to enroll them in the dental coverage under this Plan, they will not be considered Late Entrants if their dental coverage under the other plan ends due to one of the events listed below:

- Termination of Your spouse's employment.
- Loss of eligibility under Your spouse's dental plan.
- Divorce.
- Death of Your spouse.
- Termination of the other dental plan.
- Any other event as required by state or federal law or in accordance with Your Employer’s rules.

But, You must enroll Your dependents in the dental coverage under this Plan within 30 days of the date that any of the events listed above occurs.

And, Your dependents will not be considered Late Entrants if: (1) You are under legal obligation to provide dental coverage due to a court order; and (2) You enroll them in this Plan within 30 days of the issuance of the court order. **]**

## When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time. The date Your dependent coverage is scheduled to start is shown on the face page of this Certificate of Coverage.

**Exception:** We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to carry out the normal activities of someone of like age and sex. In that case, We will postpone the effective date of his or her coverage until the day after the date: (a) his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she resumes the normal activities of someone of like age and sex.

**Newborn Children:** We cover Your newborn child for dependent benefits from the moment of birth if: (1) You are already covered for dependent child coverage when the child is born; or (2) You enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If You fail to do this, once the child is enrolled, he or she: (a) is a Late Entrant; (b) is subject to any applicable Late Entrant penalties; and (c) will be covered as of the enrollment date.

## When Dependent Coverage Ends

Dependent coverage for your Spouse ends on the last day of the month when:

- Your Employee coverage ends.
- Your marriage ends in legal divorce or annulment.

Dependent coverage for your dependent children ends on the last day of the month when:

- Your Employee coverage ends.
- He or she stops being an eligible dependent.
- He or she attains the age limit.
- Your handicapped child reaches the age limit, when he or she marries or is no longer dependent on You for support and maintenance

## DENTAL EXPENSE BENEFITS

This coverage will pay many of a Covered Person's Group dental expenses. We pay benefits for covered charges incurred by a Covered Person. What We pay and terms for payment are explained below.

This Certificate includes form(s) [2][ SCH1-SUPP-PPOHIGHORTH-FF-TN ], which are the Plan's Schedule of Benefits.

### [8][ DentalGuard Preferred [5][ and DentalGuard Alliance ] -This Plan's Dental Preferred Provider Organization ]

This Plan is designed to provide high quality dental care while controlling the cost of such care. To do this, this Plan encourages a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with Guardian's dental preferred provider organizations (PPOs), which [8][ [9][ is ] called DentalGuard Preferred [5][ and DentalGuard Alliance] ].

The dental PPO is made up of Preferred Providers in a Covered Person's geographic area. Use of the dental PPO is voluntary. A Covered Person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers at any time. When You enroll in this Plan, You and Your covered dependents receive: (1) a dental plan ID card; and (2) information about current Preferred Providers.

This Plan usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider.

But, this Plan's Payment Limits differ based upon whether a Covered Person uses the services of a Preferred Provider or a Non-Preferred Provider. A Covered Person will usually be left with less out-of-pocket expense when a Preferred Provider is used.

A Covered Person must present his or her ID card when he or she uses a Preferred Provider. Most Preferred Providers prepare necessary claim forms for the Covered Person, and submit the forms to Us. We send the Covered Person an explanation of this Plan's benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Plan. Please read this Plan carefully for specific benefit levels, deductibles Payment Rates and service Payment Limits.

A Covered Person may call Guardian at the number shown on his or her ID card should he or she have any questions about this Plan.

### Covered Charges

Whether a Covered Person uses the services of a Preferred Provider or a Non-Preferred Provider, covered charges are the charges listed in the fee schedule the Preferred Provider has agreed to accept as payment in full, for the dental services listed in this Plan's List of Covered Dental Services.

To be covered by this Plan, a service must be: (1) necessary; (2) appropriate for a given condition; and (3) included in the List of Covered Dental Services.

We may use the professional review of a Dentist to determine the appropriate benefit for a dental procedure or course of treatment.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed: (1) prior to; (2) at the same time; or (3) at a later date. For benefit purposes under this Plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedures scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, We will only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred while a person is covered by this Plan.

A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is first prepared. A covered charge for any other Dental Prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened.

All other covered charges are incurred on the date the services are furnished.

## Alternate Treatment

If more than one type of service can be used to treat a dental condition, We have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by Us. For example, in the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding amalgam filling benefit.

## Proof of Claim

The Covered Person or his or her Dentist must provide Us with proof that is acceptable to Us. This proof may, at Our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document Proof of Claim and support the necessity of the proposed treatment. If We do not receive the necessary proof, We may pay no benefits, or minimum benefits. But, if We receive the necessary proof within 15 months of the date of service, We will redetermine the Covered Person's benefits based on the new proof.

## Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the Covered Person's Dentist should send Us a treatment plan before he or she starts. This must be done on a form acceptable to Us. The treatment plan must include: (1) a list of the services to be done, using the American Dental Association Nomenclature and codes; (2) the itemized cost of each service; and (3) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to Us.

We review the treatment plan and estimate what We will pay. We will send the estimate to the Covered Person and his or her Dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to Us, We have the right to base Our benefit payments on treatment appropriate to the Covered Person's condition using accepted standards of dental practice.

The Covered Person and his or her Dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what We will pay. It tells the Covered Person, and his or her Dentist, in advance, what We would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (1) the services being performed as proposed and while the person is covered; and (2) the benefit provisions, and all of the other terms of this Plan.

Emergency Treatment, oral exams, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We will not deny or reduce benefits if pre-treatment review is not done. But, what We pay will be based on the availability and submission of Proof of Claim.

## Benefits from Other Sources

Other plans may furnish benefits similar to the benefits provided by this Plan. For instance, You may be covered by this Plan and a similar plan through Your spouse's employer. You may also be covered by this Plan and a medical plan. In such instances, We coordinate Our benefits with the benefits from that other plan. We do this so that no one gets more in benefits than the charges he or she incurs. Read Coordination Of Benefits to see how this works.

## [17][ Waiting Periods for Certain Services

During the first 12 months a person is covered by this Plan, We will not cover charges for the following services:

- Group III services.
- Group IV services.

Charges We do not cover as shown above are not covered charges under this Plan, and cannot be used to meet this Plan's deductibles.

This provision does not apply to Late Entrants. See Penalty For Late Entrants for details on what charges are not covered if a person is a Late Entrant.

This provision does not apply to the Pediatric Dental Services portion of this Plan.

The Waiting Period will be waived with proof of 12 consecutive months of prior group coverage with no lapse in coverage. **]**

### [7] **[ Penalty for Late Entrants**

During the first six months that a Late Entrant is covered by this Plan, We will not cover charges for the following services:

- Group II services.

During the first 12 months a Late Entrant is covered by this Plan, We will not cover charges for the following services:

- Group III services.

During the first 24 months a Late Entrant is covered by this Plan, We will not cover charges for the following services:

- Group IV services.

Charges We do not cover as shown above are not covered charges under this Plan, and cannot be used to meet this Plan's deductibles.

We do not apply a Late Entrant penalty to covered charges incurred for services needed solely due to an Injury suffered by a person while covered by this Plan.

We do not apply a Late Entrant penalty to the Pediatric Dental Services portion of this Plan. **]**

## How We Pay Benefits for Services

**Deductible:** The Benefit Year deductible is shown in the Schedule of Benefits. Each Covered Person must have covered charges which exceed the deductible before We pay him or her any benefits for such charges. These charges must be incurred while he or she is covered.

**Payment of Benefits:** Once the deductible is met, We pay benefits for covered charges above that amount at the applicable Payment Rates for the rest of that Benefit Year. This Plan's Payment Rates are shown in the Schedule of Benefits.

**After This Coverage Ends:** We do not pay for charges incurred after a person's coverage ends.

## Rollover of Benefit Year Payment Limit

A Covered Person will be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit, as follows:

If a Covered Person submits at least one claim for covered charges during a Benefit Year and, in that Benefit Year, receives benefits that are in excess of any deductible, and that, in total, do not exceed the Rollover Threshold, he or she will be entitled to a Rollover, subject to all of the conditions described below.

Note: If all of the benefits that a covered person receives in a Benefit Year are for services provided by a Preferred Provider, he or she will be entitled to a greater Rollover than if any of the benefits are for services of a Non-Preferred Provider.

Rollovers can accrue and are stored in the Covered Person's Rollover Account. If a Covered Person reaches his or her Benefit Year Payment Limit for Group I, Group II, Group III and [12]**[** Group IV **]** Services, we pay benefits up to the amount stored in the Covered Person's Rollover Account. The amount stored in the Rollover Account cannot be greater than the Rollover Account Maximum.

A Covered Person's Rollover Account will be eliminated, and the accrued Rollover lost, if he or she has a break in coverage of any length of time, for any reason; or if the Covered Person does not submit a claim for covered charges during a Benefit Year.

The amounts of this Plan's Rollover Threshold, Rollover, and Rollover Account Maximum are:

| | |
|---|---|
| **Rollover Threshold** | ……..... [13] **[** $200.00 **]** |
| **Rollover** | ..... [14] **[** $150.00 **]** |
| | (if all benefits are for services provided by a Preferred Provider) ……..... [14] **[** $150.00 **]** |
| | (if any benefits are for services provided by a Non-Preferred Provider) ..... [14] **[** $100.00 **]** |
| **Rollover Account Maximum** | .....……..... [15] **[** $500.00 **]** |

If this Plan's dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full Benefit Year. And, if the effective date of a Covered Person's dental coverage is in October, November or December, this rollover provision will not apply to the Covered Person until January 1 of the next Benefit Year. In either case: (1) only claims incurred on or after January 1 of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Rollover Account until the Benefit Year that starts one year from the date the rollover provision first applies.

If this Plan's dental coverage first becomes effective in the three months prior to the first full Benefit Year, this rollover provision will not apply until the first day of the first full Benefit Year. And, if the effective date of a Covered Person's dental coverage is within the three months prior to the start of this Plan's next Benefit Year, this rollover provision will not apply to the Covered Person until the next Benefit Year. In either case: (1) only claims incurred on or after the start of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Rollover Account until the Benefit Year that starts one year from the date the rollover provision first applies.

If charges incurred by a Covered Person for any dental services are not covered due to the application of any of this Plan's waiting periods or penalties for Late Entrants, this rollover provision will not apply with respect to the Covered Person until the end of such period.

If such waiting period or Late Entrant penalty ends in the three months prior to the start of this Plan's next Benefit Year, this rollover provision will not apply to the Covered Person until the next Benefit Year. In that case: (1) only claims incurred on or after the start of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Rollover Account until the Benefit Year that starts one year from the date the rollover provision first applies.

## Limitations

**Teeth Lost** , **Extracted or Missing Before A Covered Person Becomes Covered By This Plan:** A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan.

## Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person’s employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker’s Compensation or similar laws.

- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for a specific cosmetic services. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least ten years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment, unless the benefit provision provides specific benefits for Orthodontic Treatment.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- Tooth transplants.
- Evaluations and consultations for non-covered services, or detailed and extensive oral evaluations**.** [10]**[**

- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant **]**.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

## LIST OF COVERED DENTAL SERVICES

The services covered by this Plan are named in this list. In order to be covered, the service must be furnished by, or under the direct supervision of, a Dentist. And, it must be usual and necessary treatment for a dental condition.

### Group I Services

### (Diagnostic & Preventive)

**Prophylaxis and Fluorides**

Prophylaxis (Adult prophylaxis covered age 12 and older): Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application: Limited to Covered Persons under age 19 and to one treatment in any six consecutive month period.

**Office Visits, Evaluations and Examination**

Comprehensive oral evaluation – limited to once every 36 consecutive months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

**Space Maintainers**

Space Maintainers: Limited to Covered Persons under age 16 and limited to initial Appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral.
- Fixed - bilateral.
- Removable - unilateral.
- Removable - bilateral.

Recementation of space maintainer performed more than 12 months after the initial insertion.

Removal of fixed space maintainer is considered once per quadrant or arch (as applicable) per lifetime.

**Fixed and Removable Appliances**

Fixed and removable Appliances to inhibit thumbsucking: Limited to Covered Persons under age 14 and limited to initial Appliance only. Allowance includes all adjustments in the first six months after insertion.

**Radiographs**

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal images- single images.

**Dental Sealants**

Dental Sealants or Preventive Resin Restoration, permanent molar teeth only: Topical application of sealants is limited to the unrestored, caries free, surfaces of permanent molar teeth of Covered Persons under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

## Group II Services

## (Basic)

**Restorative Services**

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months have passed since the previous restoration was placed if the Covered Person is age 19 or older.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: [18][ Limited to Anterior Teeth only. Coverage for resins on [19][ Posterior ] Teeth is limited to the corresponding amalgam benefit. ] Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 24 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

**Diagnostic Services**

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

**Other Services**

Injectable antibiotics needed solely for treatment of a dental condition.

## Group III Services

## (Major)

### Group III Restorative Services

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations. Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic, when done in connection with a covered surgical placement of an implant on the same tooth.

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous arch [11][.
- Dental implant supported connecting bar.
- Prefabricated abutment.
- Custom abutment.

Implant services: Allowance includes the treatment plan, local anesthetic and post-surgical care. The number of implants We cover is limited to the number of teeth extracted in the same area while the person is covered under this Plan. Also, see the Special Limitations section and Exclusions.

- Surgical placement of implant body, endosteal implant.
- Surgical placement, eposteal implant.
- Surgical placement transosteal implant.

Other implant services:

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site: Limited to once per tooth, per lifetime.
- Radiographs/surgical implant index: Limited to once per arch in any 24 month period.
- Repair implant supported prosthesis.
- Repair implant abutment.
- Implant removal. **]**

**Prosthodontic Services**

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Lower, resin base, including any conventional clasps, rests and teeth.

- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

**Crown and Prosthodontic Restorative Services**

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture rebase, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

**Endodontic Services**

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

- Root canal treatment  Root canal retreatment Limited to once per tooth, per lifetime.
- Treatment of root canal obstruction, no surgical access.
- Incomplete endodontic therapy, inoperable or fractured tooth.
- Internal root repair of perforation defects.
- Apexification: Limited to a maximum of three visits.
- Apicoectomy: Limited to once per root, per lifetime.
- Root amputation: Limited to once per root, per lifetime.
- Retrograde filling: Limited to once per root, per lifetime.
- Hemisection, including any root removal: Once per tooth.

**Periodontal Services**

Periodontal maintenance: Limited to a total of one periodontal maintenance or prophylaxis in any six month period. Allowance includes periodontal charting, scaling and polishing.  Also see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once in any 36 consecutive month period. Considered only when no diagnostic preventive , periodontal maintenance procedure, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

**Periodontal Surgery**

Allowance includes the treatment plan, local anesthetic and post-surgical care.  Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

**Periodontal Surgery Related**

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

**Non-Surgical Extractions**

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

**Surgical Extractions**

Allowance includes the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan**.

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

**Other Oral Surgical Procedures**

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Biopsy and examination of tooth related oral tissue.

Brush biopsy

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of tooth related tumors, cysts and neoplasms.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Sialolithotomy.

Sialodochoplasty.

Closure of salivary fistula. Excision of salivary gland.

Maxillary sinusotomy for removal of tooth fragment or foreign body.

Vestibuloplasty.

**Other Services**

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations [11] **[** , surgical placement of an implant **]** and services listed under Other Surgical Procedures.

## [12][ Group IV Services

## (Orthodontics)

**Covered Charges:** Subject to the terms of the Plan, we cover charges for the following services for Orthodontic Treatment for Eligible Dependents under age 19.

**Orthodontic Services:** Any covered Group I, Group II or Group III Service in connection with Orthodontic Treatment.

- Transseptal fiberotomy.
- Orthodontic records includes exams, x-rays, diagnostic photographs, diagnostic casts or cephalometric films.
- Limited Orthodontic Treatment, Interceptive Orthodontic Treatment, or Comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances and periodic visits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits: limited to initial Appliance(s) only.

A covered charge for Orthodontic Treatment is incurred on the date the Active Orthodontic Appliance is first placed.

**Treatment Plan:** A treatment plan should always be sent to us before Orthodontic Treatment starts.

**How We Pay Benefits:** This Plan provides benefits for Group IV orthodontic services only for covered dependent children who are less than 19 years old when the active orthodontic appliance is first placed.

Using the Covered Person's original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Plan. We limit what we pay for orthodontic services to the Orthodontic Lifetime Maximum payment of $1000.00. What we pay is based on all of the terms of this Plan.

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered by this Plan. Based on the original treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The benefits we pay for Orthodontic Treatment won't be charges against a Covered Person benefit year payment limits that apply to all other services.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fix and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate orthodontic treatment; and (g)

orthodontic treatment started before the member was eligible for orthodontic benefits under this Plan. Whether or not a charge is based on a discounted fee, it will be counted toward a Covered Person's orthodontic lifetime payment limited under this Plan. ]

## PEDIATRIC DENTAL SERVICES
## FOR COVERED PERSONS UNDER AGE 19

**The Provisions listed here apply to Covered Persons under the age of 19 and the List of Covered Pediatric Dental Services explained below.**

### Waiting Periods for Certain Services

During the first 24 months a person is covered by this Plan, We will not cover charges for the following services:

- Group IV services.

Charges We do not cover as shown above are not covered charges under this Plan, and cannot be used to meet this Plan's deductibles.

**T**he Waiting Period will be waived with proof of 12 consecutive months of prior group coverage with no lapse in coverage.

### Limitations

**Teeth Lost , Extracted or Missing Before A Covered Person Becomes Covered By This Plan:** A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan.

### Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least 60 months old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.

- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.

## LIST OF COVERED PEDIATRIC DENTAL SERVICES

**The list below provides the Pediatric Dental Services required by your State. If a Covered Person under the age of 19 is eligible to receive more than one dental benefit for the same service under dental coverage provided by Us, claim payments will be calculated for each benefit and the greater of the two benefits will be paid.**

### Group I Services

### (Diagnostic & Preventive)

**Prophylaxis and Fluorides**

Prophylaxis (Adult prophylaxis covered age 12 and older): Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This

does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application: Limited to Covered Persons under age 19 and to two treatments in any twelve consecutive month period.

**Office Visits, Evaluations and Examination**

Comprehensive oral evaluation – limited to once every 36 consecutive months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

**Space Maintainers**

Space Maintainers: Limited to initial Appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral.
- Fixed - bilateral.
- Removable - unilateral.
- Removable - bilateral.

Recementation of space maintainer performed more than 12 months after the initial insertion.

Removal of fixed space maintainer is considered once per quadrant or arch (as applicable) per lifetime.

**Radiographs**

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 6 consecutive month period.

Intraoral periapical or occlusal images- single images.

**Dental Sealants**

Dental Sealants or Preventive Resin Restoration, permanent molar teeth only: Topical application of sealants is limited to the unrestored, caries free, surfaces of permanent molar teeth. Limited to one treatment, per tooth, in any 36 consecutive month period.

## Group II Services

## (Basic)

**Restorative Services**

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 60 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

**Diagnostic Services**

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

**Other Services**

Injectable antibiotics needed solely for treatment of a dental condition.

## Group III Services

## (Major)

**Group III Restorative Services**

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations. Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic, when done in connection with a covered surgical placement of an implant on the same tooth.

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous arch.
- Dental implant supported connecting bar.
- Prefabricated abutment.
- Custom abutment.

Implant services: Allowance includes the treatment plan, local anesthetic and post-surgical care. The number of implants We cover is limited to the number of teeth extracted in the same area while the person is covered under this Plan. Also, see the Special Limitations section and Exclusions.

- Surgical placement of implant body, endosteal implant.
- Surgical placement, eposteal implant.
- Surgical placement transosteal implant.

Other implant services:

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site: Limited to once per tooth, per lifetime.
- Radiographs/surgical implant index: Limited to once per arch in any 24 month period.
- Repair implant supported prosthesis.
- Repair implant abutment.
- Implant removal.

**Prosthodontic Services**

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal

- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Lower, resin base, including any conventional clasps, rests and teeth.
- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

**Crown and Prosthodontic Restorative Services**

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture rebase, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase

is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

**Other Services**

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under Other Surgical Procedures.

Detailed and extensive oral evaluations – problem focused, by report

**Endodontic Services**

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

- Root canal treatment Root canal retreatment Limited to once per tooth, per lifetime.
- Treatment of root canal obstruction, no surgical access.
- Incomplete endodontic therapy, inoperable or fractured tooth.
- Internal root repair of perforation defects.
- Apexification: Limited to a maximum of three visits.
- Apicoectomy: Limited to once per root, per lifetime.
- Root amputation: Limited to once per root, per lifetime.
- Retrograde filling: Limited to once per root, per lifetime.
- Hemisection, including any root removal: Once per tooth.

**Periodontal Services**

Periodontal maintenance: Limited to a total of four periodontal maintenance or prophylaxis in any twelve month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once per lifetime.

**Periodontal Surgery**

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

**Periodontal Surgery Related**

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

**Non-Surgical Extractions**

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

**Surgical Extractions**

Allowance includes the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan**.

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

**Other Oral Surgical Procedures**

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Vestibuloplasty.

Tooth reimplantation.

## Group IV Services

## (Orthodontics)

**Orthodontic Services**

Prior authorization is required for Orthodontic Services. Orthodontic Services are covered when needed to due to severe, dysfunctional, handicapping malocclusion.

- Orthodontic records includes exams, x-rays, diagnostic photographs, diagnostic casts or cephalometric films.
- Limited Orthodontic Treatment, interceptive Orthodontic Treatment, or comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances and periodic visits. Minor treatment to control harmful habits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits: limited to initial Appliance(s) only.

A covered charge for Orthodontic Treatment is incurred on the date the Active Orthodontic Appliance is first placed.

**Treatment Plan**

A treatment plan should always be sent to us before Orthodontic Treatment starts.

**How We Pay Benefits for Orthodontic Services**

Using the Covered Person's original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Plan.

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered by this Plan. Based on the original treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fix and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; and (e) orthodontic treatment started before the member was eligible for orthodontic benefits under this Plan. Whether or not a charge is based on a discounted fee, it will be counted toward a Covered Person's orthodontic lifetime payment limited under this Plan.

## CONTINUATION RIGHTS

### Coordination Between Continuation Sections

A Covered Person may be eligible to continue his or her group dental coverage under more than one Continuation Rights section at the same time. If he or she chooses to continue his or her group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

A Covered Person continuing coverage under more than one continuation section: (1) will not be entitled to duplicate benefits; and (2) will not be subject to the premium requirements of more than one section at the same time.

### Uniformed Services Continuation Rights

If You enter or return from military service, You may be able to continue coverage under this Plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If Your group dental coverage under this Plan would otherwise end because You enter into active military service, You may elect to continue such coverage for yourself and Your eligible dependents in accordance with the provisions of USERRA.

Group dental coverage may be continued while You are in the military for up to 24 months starting on the date of absence from work. Continued coverage will end if You fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact Your Employee for details about this continuation provision, including required premium payments.

### COBRA Continuation Rights<br>Employee and Dependent

**Important Notice:** The Federal Continuation Rights section may not apply to Your Employer's plan. You must contact Your Employer's to find out if Your Employer's is subject to the Federal continuation rights requirement. If Your Employer's is subject to that requirement, the Federal Continuation Rights section applies to You.

**Qualified Continuee:** Under this section, the term "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group dental coverage as: (1) an active Employee or Qualified Retiree; (2) the spouse of an active Employee Qualified Retiree; or (3) the dependent child of an active Employee Qualified Retiree. A child born to, or adopted by, an active Employee Qualified Retiree during a continuation provided by this section is also a qualified continuee. Any other person who would otherwise become eligible for group dental coverage during a continuation provided by this section is not a qualified continuee.

**If an Employee's Group Dental Coverage Ends:** If Your group dental coverage would otherwise end due to Your termination of employment or reduction of work hours, You may elect to continue such coverage for up to 18 months, if You were not terminated due to gross misconduct.

The continuation: (1) may cover You or any other qualified continuee; and (2) is subject to When Continuation Ends.

**Extra Continuation for Disabled Qualified Continuees:** If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group dental coverage would otherwise end due to Your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give Your Employer written proof of Social Security's determination of his or her disability as described in The Qualified Continuee's Responsibilities. If, during the extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify Your Employer within 30 days of such determination and continuation will end, as explained in When Continuation Ends.

This extra 11 month continuation is subject to When Continuation Ends.

An additional 50% of the total premium charge also may be required from the qualified continuee and all qualified continuees who are members of the disabled qualified continuee's family by Your Employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

**Special Continuance for Retired Employees and Their Dependents:** If Your group dental coverage would otherwise end due to a bankruptcy proceeding under Title 11 of the United States Code involving the Employer, You may elect to continue such benefits, provided that: (1) You are or become a retired Employee on or before the date group dental coverage would otherwise end; and (2) You and Your dependents were covered for group dental coverage under this Plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for Your lifetime. After Your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for You and Your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If You die before the bankruptcy proceeding under Title 11 of the United States Code, Your surviving spouse and dependent children may elect to continue group dental coverage on their own behalf, provided they were covered on the day before such proceeding. The continuation can last for Your surviving spouse's lifetime.

This special continuance starts on the later of (1) the date of the proceeding under Title 11; or (2) the day after the date group dental coverage would otherwise have ended. It ends as described in When Continuation Ends, except that a person's entitlement to Medicare will not end such continuance.

**If You Die While Covered:** If You die while covered, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. The continuation can last for up to 36 months, subject to When Continuation Ends.

**If Your Marriage Ends:** If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. The continuation can last for up to 36 months, subject to When Continuation Ends.

**If a Dependent Child Loses Eligibility:** If a dependent child's group dental coverage would otherwise end due to his or her loss of dependent eligibility as defined in this Plan, other than Your coverage ending, he or she may elect to continue such coverage. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to When Continuation Ends.

**Concurrent Continuations:** If a dependent elects to continue his or her group dental coverage due to Your termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period he or she becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

**Special Medicare Rule:** If You become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after Your later termination of employment or reduction of work hours, will be the longer of: (1) 18 months (29 months if there is a disability extension) from Your termination of employment or reduction of work hours; or (2) 36 months from the date of Your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

**The Qualified Continuee's Responsibilities:** A person eligible for continuation under this section must notify [20A][ ADP ] [20B][ Your Employer ], in writing, of: (1) Your legal divorce or separation from Your spouse; (2) the loss of dependent eligibility, as defined in this Plan, of a covered dependent child; (3) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (4) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (5) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to [20A][ ADP ] [20B][Your Employer ] by a qualified continuee within 60 days of the latest of: (1) the date on which an event that would qualify a person for continuation under this section occurs; (2) the date on which the qualified continuee loses (or would lose) coverage under this Plan as a result of the event; or (3) the date the qualified continuee is informed of the responsibility to provide notice to [20A][ ADP ] [20B][ Your Employer ]and this Plan's procedures for providing such notice.

Notice of a disability determination must be given to [20A][ ADP ] [20B][ Your Employer ] by a qualified continuee within 60 days of the latest of: (1) the date of the Social Security Administration determination; (2) the date of the event that would qualify a person for continuation; (3) the date the qualified continuee loses or would lose coverage; or (4) the date the qualified continuee is informed of the responsibility to provide notice to [20A][ ADP ] [20B][ Your Employer ] and this Plan's procedures for providing such notice. But, such notice must be given before the end of the first 18 months of continuation coverage.

**Your Employer's Responsibilities:** A qualified continuee must be notified, in writing, of: (1) his or her right to continue this Plan's group dental coverage; (2) the premium he or she must pay to continue such coverage; and (3) the times and manner in which such payments must be made.

Your Employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (1) Your death; or (2) termination of employment (other than for gross misconduct) or reduction in hours of employment; or (3) Medicare entitlement; or (4) if You are a retired Employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to Your Employer. Upon receipt of notice of a qualifying event from Your Employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this Plan's group dental coverage no later than 14 days after receipt of notice.

If Your Employer is also the plan administrator, in the case of a qualifying event for which the Employer must give notice to the plan administrator, Your Employer must provide notice to a qualified continuee of the right to continue this Plan's group dental coverage within 44 days of the qualifying event.

If Your Employer determines that a person is not eligible for continued group dental coverage under this Plan, [20A][ ADP ] [20B][ Your Employer ] must notify him or her with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group dental coverage under this Plan is cancelled prior to the maximum continuation period, [XA][ ADP ] [20B][Your Employer ]must notify the qualified continuee as soon as practical following determination that the continued group dental coverage shall terminate.

**Your Employer's Liability:** Your Employer will be liable for the qualified continuee's continued group dental coverage to the same extent as, and in place of, Us, if [20A][ ADP ] [20B][ Your Employer ] fails: (1) to remit a qualified continuee's premium payment to Us on time, causing the qualified continuee's continued group dental coverage to end; or (2) to notify the qualified continuee of his or her continuation rights as described above.

**Election of Continuation:** To continue his or her group dental coverage, the qualified continuee must give [20A] ADP [20B] Your Employer written notice that he or she elects to continue. This must be done by the later of: (1) 60 days from the date a qualified continuee receives notice of his or her continuation rights from [20A] ADP [20B] Your Employer as described above; or (2) the date group dental coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to [20A] ADP [20B] Your Employer, by the qualified continuee, in advance, at the times and in the manner specified by [20A] ADP [20B] Your Employer. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group dental coverage had the qualified continuee stayed covered under the group Plan on a regular basis. It includes any amount that would have been paid by Your Employer. Except as explained in Extra Continuation For Disabled Qualified Continuees, an additional charge of two percent of the total premium charge may also be required by [20A] ADP [20B] Your Employer.

If the qualified continuee fails to give [20A] ADP [20B] Your Employer notice of his or her intent to continue, or fails to pay any required premium in a timely manner, he or she waives his or her continuation rights.

**Grace In Payment of Premium:** A qualified continuee's premium payment is timely if, with respect to the first payment after he or she elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made in an amount that is not significantly less than the amount the Plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid, unless [20] ADP [20B] Your Employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to [20A] ADP [20B] Your Employer.

**When Continuation Ends:** A qualified continuee's continued group dental coverage ends on the first of the following:

- With respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental coverage would otherwise end;
- With respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (1) the end of the 29 month period which starts on the date the group dental coverage would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- The date Your Employer ceases to provide any group dental coverage to any Employee;
- The end of the period for which the last premium payment is made;
- The date, after the date of election, a qualified continuee becomes covered under any other group dental coverage which does not contain any pre-existing condition exclusion or limitation affecting him or her;
- The date, after the date of election, the qualified continuee becomes entitled to Medicare; or
- With respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group dental coverage would otherwise end.

## Your Right to Continue Dental Expense Coverage During a Family Leave of Absence

**Important Notice:** This section may not apply to Your Employer's plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

**If Your Coverage Would End:** Your dental expense coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3)

due to Your own serious health condition; or (4) because of a serious injury or illness arising out of the fact that Your spouse, child, parent or next of kin who is a covered servicemember is on active duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

**When Continuation Ends:** Continued coverage will end on the earliest of the following:

- The date You return to Active Work.
- The end of a total leave period of 26 weeks in one 12 month period, if You care for a covered servicemember. This 26 week total leave period applies to all leaves granted to You under this section for all reasons.
- The end of a total leave period of 12 weeks in: (1) any later 12 month period, if You care for a covered servicemember; or (2) any 12 month period in any other case.
- The date on which Your coverage would have ended had You not been on leave.
- The end of the period for which premium has been paid.

**Definitions:** As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered servicemember, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

## COORDINATION OF BENEFITS

**Purpose:** When a Covered Person has coverage for dental expenses under more than one plan, this section allows this Plan to coordinate what it pays with what other plans pay. This is done so that the Covered Person does not collect more in benefits than he or she incurs in charges.

### Definitions

For the purposes of this section, the following terms are defined as:

**Allowable Expense:** This term means any necessary, reasonable, and customary item of dental expense that is covered, at least in part, by any of the plans which cover the person. This includes: (1) deductibles; (2) coinsurance; and (3) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (1) second surgical opinions; (2) precertification of admissions; and (3) preferred provider arrangements.
- If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

**Claim:** This term means a request that benefits of a plan be provided or paid.

**Claim Determination Period:** This term means a calendar year. It does not include any part of a year during which a person has no coverage under this Plan, or before the date this section takes effect.

**Closed Panel Plan:** This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides dental benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

**Coordination of Benefits:** This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

**Custodial Parent:** This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Group-Type Contracts:** This term means contracts: (1) which are not available to the general public; and (2) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.

**Plan:** This term means any of the following that provides benefits or services for dental care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) medical benefits under group or individual automobile contracts; and (5) governmental benefits, except Medicare, as permitted by law.

This term does not include: (1) individual or family insurance; (2) closed panel or other individual coverage, except for group-type coverage; (3) school accident type coverage; or (4) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

**Primary Plan:** This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

**Secondary Plan:** This term means a plan that is not a primary plan.

**This Plan:** This term means the group dental benefits provided under this group Plan.

## Order of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that apply is the rule to use.

**Non-Dependent or Dependent:** The plan that covers the person other than as a dependent (for example, as an Employee, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an Employee, subscriber, or retiree is secondary and the other plan is primary.

**Child Covered Under More Than One Plan:** The order of benefit determination when a child is covered by more than one plan is:

- If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
- If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (1) the plan of the custodial parent; (2) the plan of the spouse of the custodial parent; (3) the plan of the noncustodial parent; and (4) the plan of the spouse of the noncustodial parent.

**Active or Inactive Employee:** The plan that covers a person as an active Employee, or as that person's dependent, is primary. An active Employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired Employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

**Continuation Coverage:** The plan that covers a person as an active Employee, member, subscriber, or retired Employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

**Length of Coverage:** The plan that covered the person longer is primary.

**Other:** If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this Plan will not pay more than it would have had it been the primary plan.

## Effect on The Benefits of This Plan

**When This Plan Is Primary:** When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

**When This Plan Is Secondary:** When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

**Closed Panel Plans:** If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a Covered Person uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

## Right to Receive and Release Needed Information

Certain facts about dental coverage and services are needed to apply these rules and to determine benefits payable under this Plan and other plans. This Plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this Plan and other plans which cover the person claiming benefits. This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must provide any facts it needs to apply these rules and determine benefits payable.

## Facility of Payment

A payment made under another plan may include an amount that should have been paid by this Plan. If it does, this Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this Plan. This Plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

## Right of Recovery

If the amount of the payments made by this Plan is more than it should have paid under this section, it may recover the excess: (1) from one or more of the persons it has paid or for whom it has paid; or (2) from any other person or organization that may be responsible for benefits or services provided for the Covered Person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

**The Guardian** Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
[1][ 7 Hanover Square, New York, New York 10004
(XXX) XXX-XXXX ]

The Plan refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect.

IN THE EVENT THE COVERED PERSON IS ELIGIBLE FOR MORE THAN ONE DENTAL BENEFIT THROUGH COVERAGE PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, FOR THE SAME SERVICE, THE GREATER OF THE TWO BENEFITS WILL BE PAID.

This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan.

Please read the entire Certificate of Coverage to fully understand all terms, conditions, limitations and exclusions that apply.

**Certificate Number:** [1][ XXXXXX ]
**Employee Name:** [1][ John Doe ]
**Employee Address:** [1][ 123 Main Street, Anytown, TN XXXXX ]
**Dependent(s) under age 19:** [1][ Jane Doe ]

Date these benefits take effect: [1][ 01-01-2012 ]

## CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II, Group III and Group IV (Orthodontic) Services ..... None

**Non-Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II and Group III Services ..... $50.00
Group IV (Orthodontic) Services ..... None

## PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [2][ DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider ] and Non-Preferred Provider.

**Preferred Provider** Payment Rates:
Group I Services ..... 100%
Group II Services ..... 80%
Group III Services ..... 50%
Group IV (Orthodontic) Services ..... 50%

**Non-Preferred Provider Payment Rates:**
Group I Services ..... 80%
Group II Services ..... 60%
Group III Services ..... 30%
Group IV (Orthodontic) Services ..... 30%

## MAXIMUMS AND WAITING PERIODS

**Preferred Provider & Non-Preferred Provider** Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontics) ..... None

**Orthodontics Lifetime Maximum** ..... None

**Preferred Provider Out of Pocket Annual Maximum** ..... $700.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

**Non-Preferred Provider Out of Pocket Annual Maximum** ..... None

**Waiting Periods:**
Group I, Group II and Group III Services ..... None
Group IV (Orthodontics) Services ..... 24 Months

**The Guardian** Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
[1][ 7 Hanover Square, New York, New York 10004
(XXX) XXX-XXXX ]

The Plan refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect.

IN THE EVENT THE COVERED PERSON IS ELIGIBLE FOR MORE THAN ONE DENTAL BENEFIT THROUGH COVERAGE PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, FOR THE SAME SERVICE, THE GREATER OF THE TWO BENEFITS WILL BE PAID.

This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan.

Please read the entire Certificate of Coverage to fully understand all terms, conditions, limitations and exclusions that apply.

**Certificate Number:** [1][ XXXXXX ]
**Employee Name:** [1][ John Doe ]
**Employee Address:** [1][ 123 Main Street, Anytown, TN XXXXX ]
**Dependent(s) under age 19:** [1][ Jane Doe ]

Date these benefits take effect: [1][ 01-01-2012 ]

## CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:

| | |
|---|---|
| Group I Services | None |
| Group II & Group III Services | $75.00 |
| Group IV (Orthodontic) Services | None |

## PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [2][ DentalGuard Alliance Preferred Provider, DentalGuard Preferred Provider ].

**Preferred Provider** Payment Rates:

| | |
|---|---|
| Group I Services | 90% |
| Group II Services | 70% |
| Group III Services | 40% |
| Group IV (Orthodontic) Services | 50% |

**Non-Preferred Provider Payment Rates:**

| | |
|---|---|
| Group I Services | 0% |
| Group II Services | 0% |
| Group III Services | 0% |
| Group IV (Orthodontic) Services | 0% |

## MAXIMUMS AND WAITING PERIODS

**Preferred Provider** Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontics) ..... None

**Orthodontics Lifetime Maximum** ..... None

**Preferred Provider Out of Pocket Annual Maximum** ..... $700.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

**Waiting Periods:**
Group I, Group II and Group III Services ..... None
Group IV (Orthodontics) Services ..... 24 Months

**The Guardian** Life Insurance Company of America

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[1][ 7 Hanover Square, New York, New York 10004
(XXX) XXX-XXXX ]

The Plan refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect.

This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan.

Please read the entire Certificate of Coverage to fully understand all terms, conditions, limitations and exclusions that apply.

**Policy Number:** [2][ XXXXXX ]
**Employee:** [2][ John Doe ]
**Employee Address:** [2][ 123 Main Street, Anytown, TN XXXXX ]
**Dependent(s):** [2][ Jane Doe ]

Date these benefits take effect: [2][ 01-01-2012 ]

## CASH DEDUCTIBLE INFORMATION

Deductible per Insured per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II, Group III and Group IV (Orthodontic) Services ..... None

**Non-Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II and Group III Services ..... $50.00
Group IV (Orthodontic) Services ..... None

## PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [3][ DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider ] and Non-Preferred Provider.

**Preferred Provider** Payment Rate for:
Group I Services ..... 100%
Group II Services ..... 80%
Group III Services ..... 50%
Group IV (Orthodontic) Services ..... 50%

**Non-Preferred Provider** Payment Rate for:
Group I Services ..... 80%
Group II Services ..... 60%
Group III Services ..... 30%
Group IV (Orthodontic) Services ..... 30%

## MAXIMUMS AND WAITING PERIODS

**Preferred Provider and Non-Preferred Provider**
Annual Maximum per Covered Person..... $1,500.00

**Preferred Provider and Non-Preferred Provider**
Orthodontics Lifetime Maximum per Dependent Child..... $1,500.00

**Preferred Provider and Non-Preferred Provider Waiting Periods**
Group I and Group II Services.....None
Group III and Group IV Services (Orthodontics) .....12 Months

## PEDIATRIC DENTAL SCHEDULE
## FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained in the attached Dental Certificate of Coverage.

IN THE EVENT THE COVERED PERSON IS ELIGIBLE FOR MORE THAN ONE DENTAL BENEFIT THROUGH COVERAGE PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, FOR THE SAME SERVICE, THE GREATER OF THE TWO BENEFITS WILL BE PAID.

## PEDIATRIC DENTAL SERVICES CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II, Group III and Group IV (Orthodontic) Services ..... None

**Non-Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II and Group III Services.....$50.00
Group IV (Orthodontic) Services..... None

## PEDIATRIC DENTAL SERVICES PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [2] **[** DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider **]** and Non-Preferred Provider.

**Preferred Provider** Payment Rates:
Group I Services ..... 100%
Group II Services .....80%
Group III Services .....50%
Group IV (Orthodontic) Services.....50%

**Non-Preferred Provider Payment Rates:**
Group I Services .....80%
Group II Services .....60%
Group III Services .....30%
Group IV (Orthodontic) Services.....30%

## PEDIATRIC DENTAL SERVICES MAXIMUMS AND WAITING PERIODS

**Preferred Provider & Non-Preferred Provider** Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontics) ..... None

**Orthodontics Lifetime Maximum** ..... None

**Preferred Provider Out of Pocket Annual Maximum** ..... $700.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

**Non-Preferred Provider Out of Pocket Annual Maximum** ..... None

**Waiting Periods:**
Group I, Group II and Group III Services ..... None
Group IV (Orthodontics) Services ..... 24 Months

**The Guardian** Life Insurance Company of America

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(XXX) XXX-XXXX ]

The Plan refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect.

This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan.

Please read the entire Certificate of Coverage to fully understand all terms, conditions, limitations and exclusions that apply.

| | |
|---|---|
| **Policy Number:** | [2][ XXXXXX ] |
| **Employee:** | [2][ John Doe ] |
| **Employee Address:** | [2][ 123 Main Street, Anytown, TN XXXXX ] |
| **Dependent(s):** | [2][ Jane Doe ] |

Date these benefits take effect: [2][ 01-01-2012 ]

## CASH DEDUCTIBLE INFORMATION

Deductible per Insured per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I**,** Group II and Group III Services ..... None

**Non-Preferred Provider** Benefit Year Cash Deductible:
Group I**,** Group II and Group III Services ..... $50.00

## PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [3][ DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider ] and Non-Preferred Provider.

**Preferred Provider** Payment Rate for:
Group I Services ..... 100%
Group II Services ..... 80%
Group III Services ..... 50%

**Non-Preferred Provider** Payment Rate for:
Group I Services ..... 80%
Group II Services ..... 60%
Group III Services ..... 30%

## MAXIMUMS AND WAITING PERIODS

**Preferred Provider and Non-Preferred Provider**
Annual Maximum per Covered Person..... $1,500.00

**Preferred Provider and Non-Preferred Provider Waiting Periods**
Group I and Group II Services.....None
Group III Services.....12 Months

## PEDIATRIC DENTAL SCHEDULE
## FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained in the attached Dental Certificate of Coverage.

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## PEDIATRIC DENTAL SERVICES CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II, Group III and Group IV (Orthodontic) Services ..... None

**Non-Preferred Provider** Benefit Year Cash Deductible:
Group I, Group II and Group III Services.....$50.00
Group IV (Orthodontic) Services..... None

## PEDIATRIC DENTAL SERVICES PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [2] [ DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider ] and Non-Preferred Provider.

**Preferred Provider** Payment Rates:
Group I Services ..... 100%
Group II Services .....80%
Group III Services .....50%
Group IV (Orthodontic) Services .....50%

**Non-Preferred Provider Payment Rates:**
Group I Services .....80%
Group II Services .....60%
Group III Services .....30%
Group IV (Orthodontic) Services .....30%

## PEDIATRIC DENTAL SERVICES MAXIMUMS AND WAITING PERIODS

**Preferred Provider & Non-Preferred Provider** Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontics) ..... None

**Orthodontics Lifetime Maximum** ..... None

**Preferred Provider Out of Pocket Annual Maximum** ..... $700.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

**Non-Preferred Provider Out of Pocket Annual Maximum** ..... None

**Waiting Periods:**
Group I, Group II and Group III Services ..... None
Group IV (Orthodontics) Services ..... 24 Months

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(XXX) XXX-XXXX ]

The Plan refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect.

IN THE EVENT THE COVERED PERSON IS ELIGIBLE FOR MORE THAN ONE DENTAL BENEFIT THROUGH COVERAGE PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, FOR THE SAME SERVICE, THE GREATER OF THE TWO BENEFITS WILL BE PAID.

This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan.

Please read the entire Certificate of Coverage to fully understand all terms, conditions, limitations and exclusions that apply.

| | |
|---|---|
| **Policy Number:** | [2][ XXXXXX ] |
| **Employee:** | [2][ John Doe ] |
| **Employee Address:** | [2][ 123 Main Street, Anytown, TN XXXXX ] |
| **Dependent(s):** | [2][ Jane Doe ] |

Date these benefits take effect: [2][ 01-01-2012 ]

## CASH DEDUCTIBLE INFORMATION

Deductible per Insured per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:

| | |
|---|---|
| Group I Services | None |
| Group II and Group III Services | $75.00 |
| Group IV (Orthodontic) Services | None |

## PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [3][ DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider ].

**Preferred Provider** Payment Rate for:

| | |
|---|---|
| Group I Services | 90% |
| Group II Services | 70% |
| Group III Services | 40% |
| Group IV (Orthodontic) Services | 50% |

**Non-Preferred Provider** Payment Rate for:

| | |
|---|---|
| Group I Services | 0% |
| Group II Services | 0% |
| Group III Services | 0% |
| Group IV (Orthodontic) Services | 0% |

## MAXIMUMS AND WAITING PERIODS

**Preferred Provider Annual Maximum**
Annual Maximum per Covered Person..... $1,000.00

**Preferred Provider Orthodontic Lifetime Maximum**
Orthodontics Lifetime Maximum per Dependent Child..... $1,000.00

**Preferred Provider Waiting Periods**
Group I and Group II Services.....None
Group III and Group IV Services (Orthodontics) .....12 Months

## PEDIATRIC DENTAL SCHEDULE
## FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained in the attached Dental Certificate of Coverage.

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## PEDIATRIC DENTAL SERVICES CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I Services ..... None
Group II & Group III Services..... $75.00
Group IV (Orthodontic) Services..... None

## PEDIATRIC DENTAL SERVICES PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [3] **[** DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider **]**.

**Preferred Provider** Payment Rates:
Group I Services .....90%
Group II Services .....70%
Group III Services .....40%
Group IV (Orthodontic) Services .....50%

**Non-Preferred Provider Payment Rates:**
Group I Services .....0%
Group II Services .....0%
Group III Services .....0%
Group IV (Orthodontic) Services .....0%

## PEDIATRIC DENTAL SERVICES MAXIMUMS AND WAITING PERIODS

**Preferred Provider** Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontics) ..... None

**Orthodontics Lifetime Maximum** ..... None

**Preferred Provider Out of Pocket Annual Maximum** ..... $700.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

**Waiting Periods:**
Group I, Group II and Group III Services ..... None
Group IV (Orthodontics) Services ..... 24 Months

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The Plan refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect.

IN THE EVENT THE COVERED PERSON IS ELIGIBLE FOR MORE THAN ONE DENTAL BENEFIT THROUGH COVERAGE PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, FOR THE SAME SERVICE, THE GREATER OF THE TWO BENEFITS WILL BE PAID.

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Please read the entire Certificate of Coverage to fully understand all terms, conditions, limitations and exclusions that apply.

**Policy Number:** [2][ XXXXXX ]
**Employee:** [2][ John Doe ]
**Employee Address:** [2][ 123 Main Street, Anytown, TN XXXXX ]
**Dependent(s):** [2][ Jane Doe ]

Date these benefits take effect: [2][ 01-01-2012 ]

## CASH DEDUCTIBLE INFORMATION

Deductible per Insured per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I Services ..... None
Group II and Group III Services ..... $75.00

## PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [3][ DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider ].

**Preferred Provider** Payment Rate for:
Group I Services .....90%
Group II Services .....70%
Group III Services .....40%

**Non-Preferred Provider** Payment Rate for:
Group I Services .....0%
Group II Services .....0%
Group III Services .....0%

## MAXIMUMS AND WAITING PERIODS

**Preferred Provider Annual Maximum**
Annual Maximum per Covered Person..... $1,000.00

**Preferred Provider Waiting Periods**
Group I and Group II Services.....None
Group III Services.....12 Months

## PEDIATRIC DENTAL SCHEDULE
## FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained in the attached Dental Certificate of Coverage.

IN THE EVENT THE COVERED PERSON IS ELIGIBLE FOR MORE THAN ONE DENTAL BENEFIT THROUGH COVERAGE PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, FOR THE SAME SERVICE, THE GREATER OF THE TWO BENEFITS WILL BE PAID.

## PEDIATRIC DENTAL SERVICES CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

**Preferred Provider** Benefit Year Cash Deductible:
Group I Services .....None
Group II & Group III Services..... $75.00
Group IV (Orthodontic) Services.....None

## PEDIATRIC DENTAL SERVICES PAYMENT RATES

Preferred Provider Payment Rate for services provided by a [3] **[** DentalGuard Alliance Preferred Provider, DentalGuard Preferred Preferred Provider **]**.

**Preferred Provider** Payment Rates:
Group I Services .....90%
Group II Services .....70%
Group III Services .....40%
Group IV (Orthodontic) Services.....50%

**Non-Preferred Provider Payment Rates:**
Group I Services .....0%
Group II Services .....0%
Group III Services .....0%
Group IV (Orthodontic) Services.....0%

## PEDIATRIC DENTAL SERVICES MAXIMUMS AND WAITING PERIODS

**Preferred Provider** Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontics) ..... None

**Orthodontics Lifetime Maximum** ..... None

**Preferred Provider Out of Pocket Annual Maximum** ..... $700.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

**Waiting Periods:**
Group I, Group II and Group III Services ..... None
Group IV (Orthodontics) Services ..... 24 Months

**State:** Tennessee
**Filing Company:** The Guardian Life Insurance Company of America
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health - Dental
**Product Name:** Group Dental PPO
**Project Name/Number:** Group Dental Products Project/0146GUA01-03

## Rate Information

Rate data applies to filing.

**Filing Method:** PRIOR APPROVAL
**Rate Change Type:** Neutral
**Overall Percentage of Last Rate Revision:** 0.000%
**Effective Date of Last Rate Revision:**
**Filing Method of Last Filing:** 0

### Company Rate Information

| Company Name: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|---|---|---|---|---|---|---|---|
| The Guardian Life Insurance Company of America | 0.000% | 0.000% | $0 | 0 | $0 | 0.000% | 0.000% |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *GARD-129055732* | ***State Tracking #:*** | *H-130795* | ***Company Tracking #:*** | *0146GUA01-03* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *The Guardian Life Insurance Company of America* |
| ***TOI/Sub-TOI:*** | *H10G Group Health - Dental/H10G.000 Health - Dental* | | |
| ***Product Name:*** | *Group Dental PPO* | | |
| ***Project Name/Number:*** | *Group Dental Products Project/0146GUA01-03* | | |

## Rate/Rule Schedule

| Item No. | Schedule Item Status | Document Name | Affected Form Numbers (Separated with commas) | Rate Action | Rate Action Information | Attachments |
|---|---|---|---|---|---|---|
| 1 | | EXHIBIT 1 - EHB | GC-EHB-FFM-13-TN | New | | Exhibit 1 for TN Group EHB Rate Filing.pdf, |
| 2 | | EHHIBIT 1 - SUPP | GC-SUPP-FFM-13-TN | New | | Exhibit 1 for TN Group Supp Rate Filing.pdf, |

**Tennessee SHOP Exchange Plan Designs**

**EHB (age 18 and under)**

| | EHB High Plan | | EHB Low Plan | |
|---|---|---|---|---|
| | INN | OON | INN | OON |
| Diagnostic & Preventive | 100% | 80% | 90% | 0% |
| Basic Services | 80% | 60% | 70% | 0% |
| Major Services | 50% | 30% | 40% | 0% |
| Ortho (Med Nec) | 50% | 30% | 50% | 0% |
| Reimbursement Basis | Fee Sched | Fee Sched | Fee Sched | Fee Sched |
| Deductible | $0 | $50 NWP | $75 WP | N/A |
| Annual Maximum | N/A | N/A | N/A | N/A |
| Annual OOP Maximum | $700 | N/A | $700 | N/A |
| Ortho Lifetime Maximum | N/A | N/A | N/A | N/A |
| Waiting Periods | None | None | None | None |
| Actuarial Value | 84.6% | | 69.7% | |

**Tennessee SHOP Exchange**
**EHB Dental Rates per Child, Effective Dates 1/1/2014-3/31/2014**

| | | PPO High |
|---|---|---|
| Region 1 | Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington | $ 23.29 |
| Region 2 | Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union | $ 22.75 |
| Region 3 | Bledsoe, Bradley, Franklin, Grundy, Hamilton, Marion, McMinn, Meigs, Polk, Rhea, Sequatchie | $ 23.34 |
| Region 4 | Cheatham, Davidson, Montgomery, Robertson, Rutherford, Sumner, Trousdale, Williamson, Wilson | $ 25.90 |
| Region 5 | Benton, Carroll, Chester, Crockett, Decatur, Dyer, Gibson, Hardeman, Hardin, Henderson, Henry, Lake, Madison, McNairy, Obion, Weakley | $ 21.32 |
| Region 6 | Fayette, Haywood, Lauderdale, Shelby, Tipton | $ 23.81 |
| Region 7 | Cannon, Clay, Cumberland, DeKalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, Van Buren, Warren, White | $ 21.73 |
| Region 8 | Bedford, Coffee, Dickson, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, Stewart, Wayne | $ 22.86 |

| PPO Low |
| --- |
| $ 19.24 |
| $ 18.80 |
| $ 19.29 |
| $ 21.33 |
| $ 17.63 |
| $ 19.66 |
| $ 17.96 |
| $ 18.89 |

**Tennessee Exchange Plan Designs**

**Supplemental Plans**

| | High Plan w/o Ortho | | Low Plan w/o Ortho | | High Plan with Ortho | | Low Plan with Ortho | |
|---|---|---|---|---|---|---|---|---|
| | INN | OON | INN | OON | INN | OON | INN | OON |
| Diagnostic & Preventive | 100% | 80% | 90% | 0% | 100% | 80% | 90% | 0% |
| Basic Services | 80% | 60% | 70% | 0% | 80% | 60% | 70% | 0% |
| Major Services | 50% | 30% | 40% | 0% | 50% | 30% | 40% | 0% |
| Cosmetic Ortho (Child) | N/A | N/A | N/A | N/A | 50% | 30% | 50% | 0% |
| Reimbursement Basis | Fee Sched | Fee Sched | Fee Sched | Fee Sched | Fee Sched | Fee Sched | Fee Sched | Fee Sched |
| Deductible | 0 | $50 NWP | $75 WP | N/A | 0 | $50 NWP | $75 WP | N/A |
| Ortho Lifetime Max | N/A | N/A | N/A | N/A | $1,500 | $1,500 | $1,000 | N/A |
| Waiting Periods (Major & Ortho) | 12-month | 12-month | 12-month | 12-month | 12-month | 12-month | 12-month | 12-month |
| Included EHB Design (for <19) | High Plan | | Low Plan | | High Plan | | Low Plan | |

**Monthly Premium Rates for Tennessee SHOP Exchange**

| | |
|---|---|
| Region 1 | Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington |
| Region 2 | Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union |
| Region 3 | Bledsoe, Bradley, Franklin, Grundy, Hamilton, Marion, McMinn, Meigs, Polk, Rhea, Sequatchie |
| Region 4 | Cheatham, Davidson, Montgomery, Robertson, Rutherford, Sumner, Trousdale, Williamson, Wilson |
| Region 5 | Benton, Carroll, Chester, Crockett, Decatur, Dyer, Gibson, Hardeman, Hardin, Henderson, Henry, Lake, Madison, McNairy, Obion, Weakley |
| Region 6 | Fayette, Haywood, Lauderdale, Shelby, Tipton |
| Region 7 | Cannon, Clay, Cumberland, DeKalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, Van Buren, Warren, White |
| Region 8 | Bedford, Coffee, Dickson, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, Stewart, Wayne |

| | High Plan w/o Ortho | High Plan with Ortho | Low Plan w/o Ortho | Low Plan with Ortho |
|---|---|---|---|---|
| Rating Area 1 | | | | |
| 1 Adult | $ 20.74 | $ 20.74 | $ 16.00 | $ 16.00 |
| 1 Adult + 1 Child | $ 41.10 | $ 45.41 | $ 33.16 | $ 36.03 |
| 1 Adult + 2 Children | $ 61.47 | $ 70.09 | $ 50.32 | $ 56.06 |
| 1 Adult + 3 Children | $ 92.02 | $ 107.10 | $ 76.06 | $ 86.11 |
| 2 Adults | $ 41.52 | $ 41.52 | $ 32.04 | $ 32.04 |
| 2 Adults + 1 Child | $ 61.89 | $ 66.19 | $ 49.20 | $ 52.07 |
| 2 Adults + 2 Children | $ 82.25 | $ 90.87 | $ 66.36 | $ 72.10 |
| 2 Adults + 3 Children | $ 112.80 | $ 127.88 | $ 92.09 | $ 102.15 |
| | | | | |
| Rating Area 2 | | | | |
| 1 Adult | $ 20.17 | $ 20.17 | $ 15.56 | $ 15.56 |
| 1 Adult + 1 Child | $ 40.11 | $ 44.40 | $ 32.39 | $ 35.26 |
| 1 Adult + 2 Children | $ 60.06 | $ 68.64 | $ 49.23 | $ 54.95 |
| 1 Adult + 3 Children | $ 89.98 | $ 105.00 | $ 74.47 | $ 84.49 |
| 2 Adults | $ 40.38 | $ 40.38 | $ 31.16 | $ 31.16 |
| 2 Adults + 1 Child | $ 60.32 | $ 64.61 | $ 47.99 | $ 50.85 |
| 2 Adults + 2 Children | $ 80.27 | $ 88.85 | $ 64.82 | $ 70.54 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *GARD-129055732* | ***State Tracking #:*** | *H-130795* | ***Company Tracking #:*** | *0146GUA01-03* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *The Guardian Life Insurance Company of America* |
| ***TOI/Sub-TOI:*** | *H10G Group Health - Dental/H10G.000 Health - Dental* | | |
| ***Product Name:*** | *Group Dental PPO* | | |
| ***Project Name/Number:*** | *Group Dental Products Project/0146GUA01-03* | | |

## Supporting Document Schedules

| | |
|---|---|
| **Bypassed - Item:** | Cover Letter Accident & Health |
| **Bypass Reason:** | The pertinent information has been provided in the filing description. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Description of Variables |
| **Comments:** | Variable Memoranda |
| **Attachment(s):** | TN GC-EHB-FFM-13-TN Certificate Variable Memorandum (v1 05-22-2013).pdf<br>TN GC-EHB-FFM-13-TN Schedule Variable Memorandum (v1 05-22-2013).pdf<br>TN GC-SUPP-FFM-13-TN Variable Memorandum (v1 05-22-2013).pdf<br>TN SUPP-FFM-TN Schedules Variable Memorandum (v1 05-22-2013).pdf<br>TN GP-1-FFM-13-TN Group Insurance Policy Variable Memorandum (v1 05-22-2013).pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Filing Fees |
| **Bypass Reason:** | The domiciliary state, Connecticut, does not charge filing fees; therefore, we request that this requirement be waived. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Readability Certification |
| **Comments:** | Readability Certification |
| **Attachment(s):** | TN Readability Certification Signed.pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Third Party Authorization |
| **Bypass Reason:** | The Company is submitting its own filed; therefore, we request that this requirement be waived. |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *GARD-129055732* | ***State Tracking #:*** | *H-130795* | ***Company Tracking #:*** | *0146GUA01-03* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *The Guardian Life Insurance Company of America* |
| ***TOI/Sub-TOI:*** | *H10G Group Health - Dental/H10G.000 Health - Dental* | | |
| ***Product Name:*** | *Group Dental PPO* | | |
| ***Project Name/Number:*** | *Group Dental Products Project/0146GUA01-03* | | |

| | |
|---|---|
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Group Rates Certification/Memo - Accident & Health |
| **Comments:** | |
| **Attachment(s):** | Actuarial Memo HCR - TN (EHB Group).pdf<br>Actuarial Memo HCR - TN (Supp Group).pdf<br>TN Actuarial Rate Certification.pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Accident & Health Group Rates non-experience |
| **Bypass Reason:** | ACTUARIAL MATERIALS ATTACHED ABOVE |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

# Variable Memorandum

## Group Pediatric Dental Expense Coverage
## GC-EHB-FFM-13-TN

(1) Illustrative data is shown. It will be filled in on a case-by-case basis.

(2) The name and title of the Guardian officer may change. The Company address and telephone number may change.

(3) The page numbers will vary.

(4) This text will be deleted if there is only one preferred provider organization.

(5) Illustrative text – Schedule of Benefits form number.

(6) The specific name(s) of the preferred provider organization(s) may be changed or the text may be changed to read as "This Plan's Dental Preferred Provider Organization(s)" or "shown on the Covered Person's ID card or Our website". Text may vary to state that "Covered Person must either present his or her ID card or supply the group number and member ID when he or she uses a Preferred Provider." Text may vary to state that "Covered Person must either present his or her ID card or supply the group number and Member ID when he or she uses a Preferred Provider."

(7) This text will change to "are" if there is more than one preferred provider organization.

(8) Either the text in (8A) or (8B) will be used. The text in (8A) will be used if vendor administers the continuation, such entity's name be changed. The text in (8B) will be used if an outside vendor is not used.

# Variable Memorandum

## Group Pediatric Dental Expense Coverage

## SCH1-EHB-PPOHIGH-FFM-TN
## SCH2-EHB-PPOLOW-FFM-TN

(1) Illustrative data is shown. It will be filled in on a case-by-case basis.

(2) This text will be deleted if there is only one preferred provider organization, or the name may be changed to reflect a name change in network.

# Variable Memorandum

## Group Pediatric Dental Expense Coverage
## GC-SUPP-FFM-13-TN

(1) Illustrative data is shown. It will be filled in on a case-by-case basis.

(2) The name and title of the Guardian officer may change. The Company address and telephone number may change.

(3) The page numbers will vary.

(4) This text is deleted if a child less than age 3 is not considered a late entrant until enrolled 31 days after his or her third birthday.

(5) This text will be deleted if there is only one preferred provider organization. This text may also vary to include the actual name of the preferred provider organization.

(6) The portion of the Table of Contents included within this variable will reflect only those titles included in the Plan. For example, if a Plan does not apply Waiting Periods, the applicable text will be removed.

(7) This text will be deleted if no late entrant penalties will be applied.

(8) The specific name(s) of the preferred provider organization(s) may be changed or the text may be changed to read as "This Plan's Dental Preferred Provider Organization(s)" or "shown on the Covered Person's ID card or Our website". Text may vary to state that "Covered Person must either present his or her ID card or supply the group number and Member ID when he or she uses a Preferred Provider."

(9) This text will change to "are" if there is more than one preferred provider organization.

(10) This text will be deleted if the plan covers implants.

(11) This text will be deleted if the plan does not cover implants.

(12) This text will be deleted if Orthodontic Services are not covered by this Plan.

(13) This item may vary. The range of values for this item is from $200.00 through $1,000.00.

(14) This item may vary. The range of values for this item is from $100.00 through $500.00.

(15) This item may vary. The range of values for this item is from $500.00 through $1,500.00.

(16) This text will be deleted if the Late Entrant Penalty is not waived.

(17) This text will be deleted if no Waiting Periods are applied to the Plan.

(18) This text will be deleted if the plan covers facings or composites on posterior teeth. It may also vary to include bicuspids and anterior teeth.

(19) This text may be changed to "molar" if resins on bicuspids are covered.

(20) Either the text in (20A) or (20B) will be used. The text in (20A) will be used if vendor administers the continuation, such entity's name be changed. The text in (20B) will be used if an outside vendor is not used.

## Variable Memorandum

## Group Dental Expense Coverage

**SCH1-SUPP-PPOHIGHORTH-FFM-TN**
**SCH2-SUPP-PPOHIGH-FFM-TN**
**SCH3-SUPP-PPOLOWORTH-FFM-TN**
**SCH4-SUPP-PPOLOW-FFM-TN**

(1) Illustrative data is shown. It will be filled in on a case-by-case basis.

(2) This text will be deleted if there is only one preferred provider organization, or the name may be changed to reflect a name change in network.

## Variable Memorandum

## Group Insurance Policy

## GP-1-FFM-13-TN

(1) The name and title of the Guardian officer may change. The Company address may change.

(2) Illustrative data is shown. It will be filled in on a case-by-case basis.

(3) The page numbers will vary.

# Readability Certification

**The Guardian Life Insurance Company of America**

This is to certify that the forms listed below are in compliance with New York's Insurance Policy Readability Law.

**A. Scoring Option** *(select one)*

[X] 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _46.1_____ .

[ ] 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for each policy form are indicated below.

**B. Scope of Test** *(select one)*

[X] 1. Test was applied to entire policy form(s).

[ ] 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

**C. Standards of Certification** (A checked block indicates the standard has been achieved.)

[X] 1. The text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

[X] 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)

[X] 3. Layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

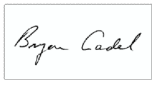
[X] 4. The section titles are captioned in bold face or otherwise stand out significantly from the text.

[X] 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

[X] 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

[X] 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.) The undersigned officer of the insurer certifies that the forms in this filing meet the minimum reading ease score. Following are the individual Flesch Scores for each form submitted with this filing:

| Form Number | Description | Combined Flesh Score |
|---|---|---|
| GP-1-FMM-13-TN | Group Insurance Policy | 46.1 |
| GC-EHB-FFM-IND-13-TN | Certificate of Coverage | 46.1 |
| GC-SUPP-FFM-13-TN | Certificate of Coverage | 46.1 |
| GC-SUPP-FFM-IND-13-TN | Certificate of Coverage | 46.1 |
| SCH1-EHB-PPOHIGH-FFM-TN | Schedule | 46.1 |
| SCH2-EHB-PPOLOW-FFM-TN | Schedule | 46.1 |
| SCH1-SUPP-PPOHIGHORTH-FFM-TN | Schedule | 46.1 |
| SCH3-SUPP-PPOLOWORTH-FFM-TN | Schedule | 46.1 |
| SCH2-SUPP-PPOHIGH-FFM-TN | Schedule | 46.1 |
| SCH4-SUPP-PPOLOW-FFM-TN | Schedule | 46.1 |



_____

Officer Signature

Bryan Cadel_____

Officer Name

2nd Vice President, Chief Compliance Officer_____

Officer Title

05-23-2013_____

Date


# Actuarial Rate Filing & Memorandum

## Plan Description

Policy form GC-EHB-SHOP-13-TN provides Group pediatric dental expense coverage for children under the age of 19. The benefit schedules covered under the policy form are SCH1-EHB-PPOHIGH-SHOP-TN and SCH2-EHB-PPOLOW-SHOP-TN, which will be referred to as the PPO High and PPO Low plans, respectively.

These Child Only dental plans pay a specified percentage of covered charges based on class of service (Diagnostic & Preventive, Basic, or Major) in excess of the deductible ($0 in-network/$50 out-of-network for High Plan, $75 for the Low Plan) where applicable. These plans are also subject to an in-network Out-of-Pocket maximum of $700.

## Purpose of Memorandum

The purpose of this actuarial memorandum is to provide actuarial justification for the initial proposed rates for The Guardian Life Insurance Company of America's new Child Only policies effective January 1, 2014. The development of these rates is intended to maintain consistency with our Group Dental rate manual. As these rates are being developed for new contracts, there is no premium history, prior experience, or loss ratios to report.

The majority of rating factors and pricing assumptions used in determining our proposed rates are consistent with those currently used for Group business in the state of Tennessee. Our Group Dental rates in Tennessee are updated on a quarterly basis and submitted to the state of New York as part of our state rate filing.

## Dental Rating Methodology

Starting Claims Cost – The average 2011 Child Only claims cost per procedure (excluding Ortho) was used to develop starting claim costs for a 100/80/50 Dental plan and an Annual Maximum of $1,300. This plan design represents the average amount of coverage for our in-force Group Dental block of business.

Existing claim costs by service code were adjusted to align with the services covered under policy form GC-EHB-SHOP-13-TN. This resulted in a starting claim cost by service category (excluding Ortho).


These nationwide starting claim costs were adjusted for trend and rating region as follows.

Trend Adjustment – Since 2011 claims data was used for the pricing analysis, the starting claims cost per Child net of coinsurance was trended by 1.5% for two years (retrospective trend) plus 5% annually for one year for a total of 8%.

Area Adjustments – Our currently filed Group area factors vs. our nationwide weighted average Group area factor was used to adjust for expected cost and utilization differences by region. Tennessee defined eight rating regions as shown in the supporting exhibit.

This result was then multiplied by the annual number of procedures per child for each service category. This allowed us to convert starting claims cost per procedure to starting claims cost per Child for each service category.

Network Adjustment – Our network discount assumptions from our currently filed Group PPO Factors were used to adjust for discounts on in-network claims. Out-of-network claims will be reimbursed at the in-network fee schedule for policy form GC-EHB-SHOP-13-TN.

Unlimited Max Adjustment – We are estimating that an unlimited maximum on Child Only Dental claims is worth a load of 1.1% vs. an annual maximum of $1,300. This load was applied to the claims cost per Child.

Deductible Adjustment – The expected cost reduction of the deductible was priced at 26% of the deductible amount when waived for preventive services. When the deductible was not waived for preventive services, the expected cost reduction was priced at 66% of the deductible amount. These percentages assume that 26% of covered children receive Basic or Major services and 66% receive any Dental service in a given year. It also assumes the deductible will be less than any allowable charge.

Coinsurance Adjustments – Our currently filed Group coinsurance adjustment factors, which vary by service category, were applied to the resulting claims cost per Child for each service category. These coinsurance adjustment factors account for both cost and utilization.

Out-of-Pocket Maximum – This coverage includes an Out-of-Pocket maximum benefit which pays 100% of in network covered services after the insured child has reached $700 of in-network out of pocket claim costs. We account for this additional cost in two ways. First, we assume that 1.8% of children are under Medically Necessary Orthodontia treatment in any given year. These children will incur out of pocket costs of $700 for Orthodontia so all in network non-Orthodontia claims will be paid at 100%. Second, we


used an estimate of the percent of children who will reach $700 in out of pocket expenses for non-Orthodontia treatments. Using a consultant's claim continuance curve, we estimated the cost of the benefits above the threshold. Both of these extra costs were added to the claim costs for each service category.

In-Network Utilization – Our in-network utilization assumptions from our currently filed Group PPO Factors were used to blend the in-network and out-of-network net Child claims costs.

**Ortho Rating Methodology**

In-Network Starting Claims Cost –We expect the charge for medically necessary orthodontia treatment to be in line with our 36-month fee schedule reimbursement schedule.

We estimate that 0.90% of covered Children will require a medically necessary Orthodontia treatment. This is based on a 3% assumption of Children having an orthodontia claim coupled with a 30% assumption of orthodontia treatments expected to be medically necessary.

Network Adjustment – We assumed that our orthodontia fee schedule was discounted 25% vs. out-of-network orthodontia charges.

Out-of-Network Starting Claims Cost – The network adjustment was backed out of the In-Network Starting Claims Cost to derive the Out-of-Network Starting Claims Cost.

Coinsurance Adjustments – For the PPO High and PPO Low plans, an adjustment of 50% was applied to the in-network starting claims cost and an adjustment of 30% was applied to out-of-network claims costs.

OOP Max Adjustment – The average in-network orthodontia charge was split into 8 quarterly payments to calculate Guardian's expected payment net of the annual out-of-pocket maximum.

In-Network Utilization – Our in-network utilization assumption for pediatric orthodontia coverage was assumed to be 95%. This was used to blend the in-network claim costs net of coinsurance and the out-of-pocket maximum with the out-of-network starting claim costs.


## Other Adjustments

On November 20, 2012, CMS published CMS Form Number: CMS-10433: Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations. A part of the collection of this data will be in the form of templates intended to create a nationwide standard of plan- and issuer-level data collection for the use of QHP certification, exchange operations, and oversight activities.

Three or More Children:

> In order to complete the rates template for Stand-Alone Dental Products, we are required to enter an individual per Child rate that would be multiplied by the number of children, capping at three for employees with three or more children.
>
> In order to avoid deficiency in our rates for groups with three or more children, we are applying an adjustment of 1.05 to our individual per Child rate submitted in the rates template.

## Final Rates

The net Dental and Orthodontia claims costs are added together to determine the overall Child Only claims cost. We are estimating average morbidity will be similar to what we assume for a 25 life group. The overall cost is then divided by a TLR assumption of 65% in order to produce the premium rates for the PPO High and PPO Low plans. Please refer to Exhibit I for the plan designs and premium rates. The actuarial values of the PPO High and PPO Low plans are 84.6% and 69.7%, respectively.

We are also filing our current nationwide quarterly dental trend factor of 1.25%, which is intended to keep premium rates from lagging behind anticipated increases in dental claims costs. This quarterly rate increase will impact premium rates only on policyholder anniversaries.

## Actuarial Certification

I, Anthony J. Tobia, am a member of the American Academy of Actuaries and meet its qualification standards for preparing rate filings. This actuarial memorandum has been prepared for the sole purpose of demonstrating the proposed rate schedules are reasonable and this memorandum may not be appropriate for other purposes. In my opinion, the premium rates and rating methodology to which this certification applies are neither excessive, inadequate nor unfairly discriminatory, and they meet the requirements of the

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insurance laws and regulations of Tennessee. The premium and rating methodology to which this certification applies also conforms to all applicable Actuarial Standards of Practice, including ASOP no. 8.

5/30/2013

Anthony J. Tobia, FSA, MAAA
Associate Actuary
Group Products - Actuarial

Date


# Actuarial Rate Filing & Memorandum

## Plan Description

Certificate GC-SUPP-SHOP-13-TN provides Group dental expense coverage for covered persons and their dependents. These plans pay a specified percentage of covered charges based on class of service (Diagnostic & Preventive, Basic, or Major) in excess of the deductible, where applicable. This policy is also subject to Annual and Lifetime maximums (depending on whether Orthodontia is covered). These plans also incorporate the pediatric dental services which are part of the essential health benefits as defined by the state of Tennessee.

There are four benefit schedules. The first covers Orthodontia and includes an EHB benefit with an 84.6% Actuarial Value. The benefit schedule for this plan is SCH1-SUPP-PPOHIGHORTH-SHOP-TN and will be referred to as the High Plan with Ortho. The second does not cover Orthodontia and includes an EHB benefit with an 84.6% Actuarial Value. The benefit schedule for this plan is SCH1-SUPP-PPOHIGH-SHOP-TN and will be referred to as the High Plan w/o Ortho. The third plan covers Orthodontia and includes an EHB benefit with an Actuarial Value of 69.7%. The benefit schedule for this plan is SCH4-SUPP-PPOLOWORTH-SHOP-TN and will be referred to as the Low Plan with Ortho. The forth plan does not Orthodontia and includes an EHB benefit with an Actuarial Value of 69.7%. The benefit schedule for this plan is SCH4-SUPP-PPOLOW-SHOP-TN and will be referred to as the Low Plan w/o Ortho.

## Purpose of Memorandum

The purpose of this actuarial memorandum is to provide actuarial justification for the initial proposed rates for The Guardian Life Insurance Company of America's new Supplemental policies effective January 1, 2014. The development of these rates is intended to maintain consistency with our Group Dental rate manual. As these rates are being developed for new contracts, there is no premium history, prior experience, or loss ratios to report.

The majority of rating factors and pricing assumptions used in determining our proposed rates are consistent with those currently used for Group business in the state of Tennessee. Our Group Dental rates in Tennessee are updated on a quarterly basis and submitted to the state of New York as part of our state rate filing.


## Dental Rating Methodology

We used our Group rate manual effective 1/1/2013, to develop a rate for a 100/80/50 passive PPO plan design for group sizes 16-49. These rates assume an annual maximum of $1,000. The expected loss ratio for these starting rates is 65.5%.

In order to derive expected non-Orthodontia claim costs for the four plans, we extracted claims from the manual rates above and applied factors from our rate manual to reflect the plan designs depicted in the Supplemental schedules referenced above. The adjustments accounted for:

- Area
- Coinsurance
- Deductible
- Annual Maximum
- Moved or Non-Covered Services
- Out of Network claims which will be reimbursed at the in-network fee schedule
- Any associated network impacts (utilization, redirection) resulting from the new plan design
- 5% Annual Trend

We are estimating average morbidity will be similar to what we assume for a 25 life group.

The result was a four-tier rate (Individual, Individual + Spouse, Individual + Children, Family) for each of Tennessee's eight rating areas consistent with our rate manual.

## Inclusion of Essential Health Benefits

Because these plans include coverage of the pediatric Dental component of Essential Health Benefits, we need to reflect the additional cost of three claim components for children aged 18 and below. Essential Health Benefits require an Unlimited Annual Maximum, a $700 Out of Pocket Maximum (after which, all in network claims are paid at 100%), and coverage for Medically Necessary Orthodontia with no Lifetime Maximum.

### Unlimited Annual Maximum

In order to calculate the cost of an Unlimited Annual Maximum, we used factors from a consultant rate manual to estimate expected impact on Child claim costs. The result was

a 0.74% load relative to a $1,500 Annual Maximum for the High plans and a load of 1.47% relative to a $1,000 Annual Maximum for the Low plans .

Impact of Out-of Pocket Maximum on Non-Ortho Claims

This coverage includes an Out-of-Pocket maximum benefit which pays 100% of in network covered services after the insured child has reached $700 of in-network out of pocket claim costs. We account for this additional cost in two ways. First, we assume that 1.8% of children are under Medically Necessary Orthodontia treatment in any given year. These children will incur out of pocket costs of $700 for Orthodontia so all in network non-Orthodontia claims will be paid at 100%. Second, we used an estimate of the percent of children who will reach $700 in out of pocket expenses for non-Orthodontia treatments. Using a consultant's claim continuance curve, we estimated the cost of the benefits above the threshold. Both of these extra costs were added to the child claim costs.

Medically Necessary Orthodontia

- In-Network Starting Claims Cost –We expect the charge for medically necessary orthodontia treatment to be in line with our 36-month fee schedule reimbursement schedule.
- We estimate that 0.90% of covered Children will require a medically necessary Orthodontia treatment. This is based on a 3% assumption of Children having an orthodontia claim coupled with a 30% assumption of orthodontia treatments expected to be medically necessary.
- Network Adjustment – We assumed that our orthodontia fee schedule was discounted 25% vs. out-of-network orthodontia charges.
- Out-of-Network Starting Claims Cost – The network adjustment was backed out of the In-Network Starting Claims Cost to derive the Out-of-Network Starting Claims Cost.
- Coinsurance Adjustments – For the PPO High and PPO Low plans, an adjustment of 50% was applied to the in-network starting claims cost and an adjustment of 30% was applied to out-of-network claims costs.
- OOP Max Adjustment – The average in-network orthodontia charge was split into 8 quarterly payments to calculate Guardian's expected payment net of the annual out-of-pocket maximum.
- In-Network Utilization – Our in-network utilization assumption for pediatric orthodontia coverage was assumed to be 95%. This was used to blend the in-network claim costs net of coinsurance and the out-of-pocket maximum with the out-of-network starting claim costs.


**Cosmetic Orthodontia Rating Methodology (when included)**

We used our current rate manual to calculate an expected Orthodontia claim cost for the plan designs depicted in the Supplemental schedules referenced above for each of Tennessee's eight rating areas. Since we estimate that 30% of Orthodontia is Medically Necessary and included as part of the Essential Health Benefits, we calculate the cosmetic Orthodontia benefit cost as 70% of the amount derived by our rate manual.

**Final Rates**

The net Dental and Orthodontia claim costs are added together for each of the four plan designs. The overall cost is then divided by a Target Loss Ratio assumption of 65% in order to produce the premium rates for the four plan designs. Please refer to Exhibit I for the plan designs and premium rates.

We are also filing our current nationwide quarterly dental trend factor of 1.25%, which is intended to keep premium rates from lagging behind anticipated increases in dental claims costs. This quarterly rate increase will impact premium rates only on policyholder anniversaries.

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**Actuarial Certification**

I, Anthony J. Tobia, am a member of the American Academy of Actuaries and meet its qualification standards for preparing rate filings. This actuarial memorandum has been prepared for the sole purpose of demonstrating the proposed rate schedules are reasonable and this memorandum may not be appropriate for other purposes. In my opinion, the premium rates and rating methodology to which this certification applies are neither excessive, inadequate nor unfairly discriminatory, and they meet the requirements of the insurance laws and regulations of Tennessee. The premium and rating methodology to which this certification applies also conforms to all applicable Actuarial Standards of Practice, including ASOP no. 8.

Anthony J. Tobia, FSA, MAAA
Associate Actuary
Group Products - Actuarial

5/30/2013
Date

**GROUP RATE CERTIFICATION**

Please check one or both of the boxes to indicate the type of rate methodology which will be used with this form. If you check only the first box you are certifying that the rates are based solely on the claims experience of a single group policyholder, not the insurance company's experience.

Please have the actuary preparing this document sign the certification below. This must be an actual signature, not computer generated or rubber stamped.

☐ As to experience-rated group insurance, premium rates and classifications need not be filed, however, form filings must be certify by signing below (i) the policy filing is experience-rated group insurance, and (ii) the premium rates and classification of risks are available for review by the Commissioner of Insurance upon request.

☐ As to other than experience-rated group insurance, the applicable premium rates and classifications must accompany the form filing, and the filing must certify by signing below that the premium rates are not unreasonable in relation to benefits provided, and that actuarial data and experience shall be maintained by the company and available for review by the Commissioner of Insurance upon request.

Signature _____

Print name _____

Title _____